Welcome and thank you for choosing us to be a part of your healthcare.

Before we start, we like to remind you that:

- We treat the whole person, not the body parts. If there are any areas of your body that you do not wish us to treat, please let the doctor know immediately.

- If there are no recent X-rays or MRI studies, only instrument style adjustments will be performed.

- This is a private property. Taking photographs, audio or video recording of any kind is not permitted.

- Your treatment will be a combination of chiropractic and physical therapy treatments in every session.

As it relates to **this office** and its healthcare providers:

- Medicaid – We do not participate with.
- Aetna – Some plans are accepted.
- CIGNA – We are out of network for physical therapy services.
- Kaiser – Does not cover evaluations and physical therapy.
- Medicare – Does not cover evaluations and physical therapy.
- United HealthCare – You must also compete the START form, the DASH form and the Lower Extremity form. These forms will be provided to you in the office.

Patient SIGNATURE/ Parent or Legal Guardian _____ Date _____

ARASH SARABI, D.C. CHIROPRACTIC, PHYSICAL THERAPY, NERVE STUDIES
121 congressional Lane #403 Rockville, MD 20852 Phone: (240) 418-9239 Fax: (240) 559-0102

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

CONFIDENTIAL PATIENT INFORMATION

PLEASE DO NOT PROVIDE ANY CONTACT INFORMATION YOU DO NOT WISH TO BE CONTACTED BY

YOUR NAME: _____ AGE: _____
FIRST MI LAST

HOME ADDRESS: Street _____ City _____ Zip _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

GENDER: M F DATE OF BIRTH: _____ ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SINGLE ☐SEPARATED

YOUR EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____

EMERGENCY PHONE #: _____ CONTACT NAME: _____ RELATIONSHIP: _____

YOUR FAMILY PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

WHO IS THE PRIMARY INSURED PERSON ☐ MYSELF ☐ MOTHER ☐ FATHER ☐ SPOUSE ☐ OTHER

PRMARY INSURED'S NAME: ☐ MYSELF ☐ OTHER: _____ DOB: _____

IS YOUR CONDITION AS A RESULT OF ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ NEITHER

PLEASE LIST THE AREAS YOU WISH TO BE TREATED FOR BELOW:

(Also let us know if there are any treatments you do not wish to receive.)

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HOW BAD HAS YOUR PAIN BEEN IN THE PAST THREE DAYS?

Please indicate which side:			No Pain = 0									Most Pain (911) = 10
Headaches			0	1	2	3	4	5	6	7	8	9	10
Neck Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Upper Back Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Shoulder Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Elbow Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Hand Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Pain in Fingers	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Hip Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Knee Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Ankle Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Foot Pain	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Pain in The Toes	Right	Left	0	1	2	3	4	5	6	7	8	9	10

_____ _____
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MEDICAL HISTORY
THIS INFORMATION HELPS US KEEP YOU SAFE

☐ Anxiety	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Autoimmune Disease	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Blood Clots	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Cancer	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Cardiovascular Illness	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Degenerative Joint Disease	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Depression	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Diabetes	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Dizziness / Vertigo	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Eating Disorders	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ EDI	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Hepatitis	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ High Blood Pressure	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ High Cholesterol	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ HIV	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Incontinence	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Insomnia	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Limes Disease	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Liver Disease	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Loss of vision and/or hearing	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Mental Illness	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Numbness and Tingling	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Respiratory Illness	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Rheumatoid Arthritis (Diagnosed)	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Scoliosis	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Stroke	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Thyroid Dysfunction	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Underweight	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings
☐ Unexplained Weakness	☐ Now	☐ Before	☐ Myself	☐ Mother ☐ Father ☐ Siblings

POSSIBLE RISK FACTORS TO TREATMENT (IF YOU HAVE ANY QUESTIONS PLEASE ASK)

- ☐ Pacemaker
- ☐ Battery Operated Implanted Devices
- ☐ Fractures
- ☐ Dislocations / Instability
- ☐ Metal Inside the Body
- ☐ Allergies Shellfish, Latex or Sulfides
- ☐ Pregnancy
- ☐ Bone Loss / Rheumatoid Arthritis / Marfan's Syndrome
- ☐ History of Dizziness / Vertigo / Light Headedness / Stroke / Paralysis

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PLEASE TAKE THE TIME TO COMPLETE THIS INFORMATION BELOW. THE MORE WE KNOW, THE MORE WE CAN HELP.

When and how did your condition(s) begin? _____

Is your condition: ☐ Staying the same ☐ Getting worse ☐ Getting better

Have you had any other treatment for this condition? ☐ Y ☐ N ☐ Physical Therapy ☐ Chiropractic Care

☐ Hospital ☐ Family Physician ☐ Other: _____

Where and when? _____

Any other treatment? _____

Prior Episodes? ☐ Y ☐ N if yes please explain: _____

Please describe your activities of daily living & Work Activities: _____

What makes you feel better? ☐ Rest ☐ Hot Showers ☐ Cold Packs ☐ Lying Down ☐ Painkillers ☐ Stretching

What makes you feel worse? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Climbing Stairs ☐ Washing Dishes

Does your pain radiate to another part of your body? ☐ Arms ☐ Hands ☐ Thighs ☐ Calf / Shin ☐ Feet / Toes

Are your symptoms ☐ constant or do they ☐ come and go? _____

Any prior ☐ Injuries, ☐ falls, ☐ broken bones or ☐ dislocations? ☐ Y ☐ N _____

Prior ☐ automobile accident or ☐ work-related injuries? ☐ Y ☐ N _____

Any ☐ surgeries? Any ☐ metal inside the body? ☐ Y ☐ N _____

Any previous ☐ X-Rays or ☐ MRI Studies? ☐ Y ☐ N _____

Have you ever received any previous ☐ physical therapy / ☐ chiropractic care for any condition? ☐ Y ☐ N _____

Current medications: _____

Vitamins & supplements: _____

Exercise habits: ☐ Daily ☐ 2-3 Times a week ☐ Once a week ☐ Never Smoke Cigarettes? ☐ Y ☐ N _____

Are you currently under treatment for any other condition? ☐ Y ☐ N _____

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NECK DISABILITY INDEX QUESTIONNAIRE – COMPLETE THIS PAGE ONLY IF YOU ARE HAVING NECK PAIN

Instructions: This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section with the ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches, which come infrequently.
- ❑ I have moderate headaches, which come infrequently.
- ❑ I have moderate headaches, which come frequently.
- ❑ I have severe headaches, which come frequently.
- ❑ I have headaches almost all the time.

Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need help every day in most aspects of self-care.
- ❑ I need some help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

Reading

- ❑ I can read as much as I want with no pain in my neck.
- ❑ I can read as much as I want with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I can't read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all because of severe pain in my neck.

Concentration

- ❑ I can concentrate fully when I want with no difficulty.
- ❑ I can concentrate fully when I want with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want.
- ❑ I have a lot of difficulty in concentrating when I want.
- ❑ I have a great deal of difficulty in concentrating when I want.
- ❑ I cannot concentrate at all.

Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1 – 2 hr's. sleepless).
- ❑ My sleep is moderately disturbed (2 – 3 hr's. sleepless).
- ❑ My sleep is greatly disturbed (3 – 5 hr's. sleepless).
- ❑ My sleep is completely disturbed (5 – 7 hr's. sleepless).

Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

Recreation

- ❑ I am able to engage in all my recreational activities with no neck pain at all.
- ❑ I am able to engage in all my recreational activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ❑ I can hardly do any recreational activities because of pain in my neck.
- ❑ I can't do any recreational activities at all.

_____

Patient SIGNATURE/ Parent or Legal Guardian

Date _____

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OSWESTRY LOW BACK PAIN QUESTIONNAIRE – COMPLETE THIS PAGE FOR LOW BACK PAIN

Pain Intensity

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

Sitting

- ❑ I can sit in any chair as long as I like without pain.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than ½ hour.
- ❑ Pain prevents me from sitting more than ten minutes.
- ❑ Pain prevents me from sitting at all.

Personal Care (Washing, Dressing, etc.)

- ❑ I do not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

Walking

- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than one mile.
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk while using a cane or on crutches.

Standing

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain while standing, but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.

Standing (Continued…)

- ❑ I cannot stand for longer than ten minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

Sleeping

- ❑ I get no pain in bed.
- ❑ I get pain in bed, but it does not prevent me from sleeping well.
- ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter.
- ❑ Because of pain, my normal night's sleep is reduced by less than one-half.
- ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ❑ Pain prevents me from sleeping at all.

Traveling

- ❑ I get no pain while traveling.
- ❑ I get some pain while I travel, but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

Social Life

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of my pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ❑ Pain has restricted my social life and I do not go out very much.
- ❑ I have hardly any social life because of the pain.
- ❑ I can't drive my car at all because of the pain.

Changing Degree of Pain

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates, but overall is definitely getting better.
- ❑ My pain seems to be getting better, but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening

Patient SIGNATURE/ Parent or Legal Guardian

Date _____

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PATIENT'S AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

I authorize the release of any of my medical and billing records reports to be forwarded to Dr. Arash Sarabi, D.C. and from Dr. Arash Sarabi, D.C. to any other entity or individual via fax, email or U.S. mail. If you do not want us to discuss your medical information including your appointment time and date with anyone including your spouse or your family members, please let us know at this time.

_____ _____
Patient SIGNATURE/ Parent or Legal Guardian Date

PATIENT'S AUTHORIZATION FOR THE INSURANCE COMPANY TO PAY DOCTOR DIRECTLY

I understand that I am personally responsible for the payment of services rendered to me by Dr. Arash Sarabi, D.C. I hereby authorize the assignment of the benefits that I am eligible to receive for the care rendered directly to Dr. Arash Sarabi, D.C. Verification of my insurance is not a guarantee of payment. I understand that if for any reason my insurance does not pay for the services rendered to me, I will be personally responsible to pay for those services. Co-pays, deductibles & other payments are due at the time the services are rendered.

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO REMIT PAYMENTS DIRECTLY TO:
METRO PHYSICAL THERAPY & CHIROPRACTIC CENTER, LLC
121 CONGRESSIONAL LANE #403 ROCKVILLE, MD 20852

PATIENT'S REQUEST TO RECEIVE HEALTH CARE SERVICES & INFORMED CONSENT

Acknowledgement:

Risks associated with physical therapy and chiropractic care include broken bones, sprains, strains, muscle, tendon and cartilage tears, injuries to the nervous system, stroke, paralysis and death. Patients are examined before any treatment is provided to address safety with the proposed treatment plan. There are certain conditions however, which may give rise to complications with physical therapy and/or chiropractic manipulations. Therefore, it is very important to let the doctor know about these conditions BEFORE the treatments are rendered. This way, the doctor can rule out any risk factors and determine the most appropriate treatment plan.

Other Options:

There are other options available to you other than chiropractic care, which may be beneficial to you and your condition. These treatment options may include surgery, drugs or injections.

Risks of Not Being Treated:

The risks of not receiving treatment may include permanent loss of function, strength, sensation, increased pain and joint degeneration.

Referrals and Recommendations:

Treatment of your condition may require referrals to specialists and/or diagnostic procedures such as X-rays or MRI studies. Follow-up with these recommendations and referrals are the patient's responsibility. Not following with the recommended treatment plan and/or missing your scheduled treatment sessions will be interpreted as withdrawal from care against doctor's advice. I have carefully read and understand the above information and am fully aware of what I am signing. I understand that I may ask the doctor for a more detailed explanation. By signing below, I do hereby voluntarily consent to be evaluated and receive physical therapy and chiropractic treatments.

_____ _____
Patient SIGNATURE/ Parent or Legal Guardian Date

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NOTICE OF PRIVACY PRACTICE AND CONFIDENTIALITY OF HEALTHCARE INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003 and applies to all protected health information contained in your health records maintained by us.
We have the following duties regarding the maintenance, use and disclosure of your health records:
There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.
We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.
Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may be necessary in your case.
Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, related healthcare data processing through our system.
Operations: We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.
Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an EMERGENCY TREATMENT SITUATION. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.
You have certain **rights regarding your health record information**, as follows:
You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. (2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. (3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. (4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion. (5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period. (6) If this notice was initially provided to you electronically, **you have the right to obtain a paper copy of this notice and to take one home with you if you wish. Please ask.**

_____ _____
Patient SIGNATURE/ Parent or Legal Guardian Date