CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2 INSURANCE INFORMATION

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (______) ____________ Home Phone (______) ____________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ____________ Relationship ____________

Home Phone (______) ____________ Work Phone (______) ____________

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________________

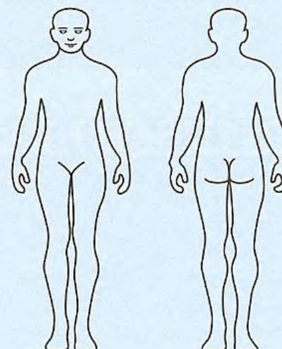
5 PATIENT CONDITION

Reason for Visit ______________________

When did your symptoms appear? ______________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______________________

Is it constant or does it come and go? ______________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other ______

Name and address of other doctor(s) who have treated you for your condition ______

Date of Last: Physical Exam ______ Spinal X-Ray ______ Blood Test ______

Spinal Exam ______ Chest X-Ray ______ Urine Test ______

Dental X-Ray ______ MRI, CT-Scan, Bone Scan ______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ______		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day ______
☐ Alcohol Drinks/Week ______
☐ Coffee/Caffeine Drinks Cups/Day ______
☐ High Stress Level Reason ______

Are you pregnant? ☐ Yes ☐ No Due Date ______

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name ______		
Pharmacy Phone (____) ______		

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_______________

Patient Name_______________

Date of Accident_______________ Time of Accident_______________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_______________

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_______________

ACCIDENT SITE

Road/Street Name_______________

City/State_______________

Nearest intersection with road/street_______________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _______________

Which direction were you headed? _______________

Speed you were traveling?_______________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_______________

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_______________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_______________

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_______________

Which direction was other vehicle headed?_______________

Speed other vehicle was traveling_______________

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_______________

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?______________________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital______________________________ Name of doctor______________________________

Diagnosis____

____

Treatment received____

X-rays taken____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?____________

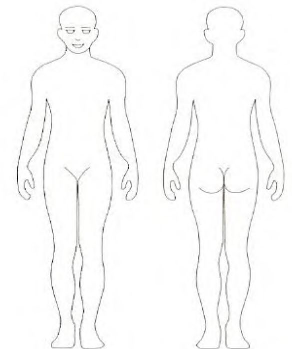
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other______________

How often do you have this pain?____

Is it constant or does it come and go?______________________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

COAST REHABILITATION
1500 E. KATELLA AVE. SUITE G
ORANGE, CALIFORNIA 92867
714-639-7654 FAX 714-639-8578

ATTORNEY LIEN

Patient's Name:____ Date of Accident:___________________

I do hereby authorize **Dr. Kelly K. Lucas** to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums as may be due and owing her for the medical services rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the doctor. And I hereby further give a Lien on my case to the doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the doctor for all medical bills submitted by her for services rendered to me and that this agreement is made solely for the doctor's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover the fee.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable by me.

______________________________ ________________________________ Date:____________
Patient's Name (Print) Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate the doctor above-named. Attorney further agrees -that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

______________________________ ________________________________ Date:____________
Attorney's Name (Print) Attorney's Signature

Name and Address of Attorney's Office:____

____

____

Office #:(______)_________________________ Fax #:(______)_________________________

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT'S NAME:____

INSURED:____

DATE OF INJURY:____

CLAIM #:____

I hereby authorize and direct ____________________________________ Insurance Company, to pay to **Dr. Kelly Lucas** such sums as may be due and owing her for chiropractic services rendered to me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the doctor. And I hereby further request that payment be made directly to the doctor, which would otherwise be paid to me, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to the doctor for all medical bills submitted by her for services rendered to me and that this agreement is made solely for the doctor's protection and in consideration of her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if I do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____________________________ ______________________________ Date:______________

Patient's Name (Print) Patient's Signature

The undersigned Insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate the doctor above and below named and make payment payable directly to the doctor.

Please Date, Sign And Return One Copy To The Doctor's Office Below:

_______________________________________ _______________________________________

Insurance Company Representative's Name (Print) Insurance Company Name

_______________________________________ Date:__________________________________

Signature of Insurance Company Representative

Name Of Clinic And Address Of Which This Form Is To Be Fax Or Returned To:

Coast Rehabilitation
1500 E. Katella Ave. Ste. G
Orange, CA 92867
Off.(714) 639-7654
Fax (714) 639-8578

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment. Including but not limited to fractures, disc injuries strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment based on the facts known at the time of service based on my best interests, during the course of treatment.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. I consent to this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To Be Completed By Patient:

________________________________ ________________________________ Date:______________

Patient's Name (Print) Patient's Signature

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

________________________________ ________________________________ Date:______________

Parent or Legal Guardian's Name Parent or Legal Guardian's Signature

Female Patient's Only:

This is to certify that to the best of my knowledge, I am **NOT** pregnant and that Dr. Kelly Lucas **DOES** have my permission to take x-rays. (Please enter the first day of your last period): _______ / _______ / _______

________________________________ Date:____________

Patient's Signature

This is to certify that to the best of my knowledge, I **AM** pregnant and that Dr. Kelly Lucas **DOES NOT** have my permission to take x-rays. Please enter how many months/weeks pregnant you are:________________________

________________________________ ________________________________ Date:______________

Estimated Due Date Patient's Signature

Name and Address of Clinic:

Coast Rehabilitation
1500 E. Katella Ave., Ste. G
Orange, CA 92867

Doctors Treating this Patient:

- Kelly K. Lucas, D.C.
Homa Bakhtar, D.C
John R. Kole, D.C

Financial Agreement

We would like you to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled. All patient portions of charges for treatment in this office are due and payable at the time the service is performed. The first visit is to be paid in full at the time of service for all patients with or without insurance benefits (except workman's compensation or personal injury). **Please Initial where it applies.**

Payment Plans

_______**PRIVATE PAY:** I agree to pay for each visit at the time of service or I will agree to prepay for visits on a weekly/monthly basis. *Discounts are offered with prepaid visit plans. *

_______**PRIVATE/GROUP INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and my co-insurance amount at the time of service or prepay on a weekly/monthly basis. I will pay for the first visit in full at the time of service. That payment will be applied toward my yearly deductible, co-insurance amount or will be fully refunded if my insurance pays 100%. * As a courtesy our staff will verify your health insurance benefits but we cannot guarantee payment or the accuracy of benefits quoted.*

_______**MEDICARE:** I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment amount for covered services and for all non covered services such as: x-rays, vitamins/supplements, pillows or supports.

_______**PERSONAL INJURY:** I agree to allow Dr. Kelly Lucas to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no medical coverage is available with my auto insurance or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred. If medical coverage is not available on my auto insurance policy my private health insurance may be billed.

_______**ATTORNEY LIEN:** I understand that Dr. Kelly Lucas has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

_______**3rd PARTY CLAIM (No Attorney):** I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree that I am personally responsible to pay charges incurred on a daily/weekly/monthly basis or at the time of settlement of my claim.

_______**WORKMAN'S COMPENSATION:** I understand that I am filing a worker's compensation claim. I also understand that if I do not follow the doctor's recommendations for care or if I miss appointments my claim may be denied. If my claim is denied because of my failure to follow the doctor's recommendation for treatment or because I miss appointments I understand I will be responsible and liable for the balance of the bill.

_______**MISSED APPOINTMENT FEE:** I understand and Agree to pay a fee of $25.00 upon a missed appointment that I did not cancelled within a 24 hr notice. I understand that this fee includes a massage appointment as well, if I did not cancel within the 24 hr period.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I Have Read And I Agree To The Above:

________________________________ Date:____________

Patient's Signature

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

________________________________ Date:____________

Parent or Legal Guardian's Signature

NOTICE OF PRIVACY PRACTICES*

WE CARE ABOUT YOUR PRIVACY

Dr. Kelly K. Lucas, DC
1500 East Katella Ave. Unit G
Orange, CA 92867
714-639-7654

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need those records to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

*These privacy practices are currently in effect and will remain in effect until further notice.

2. Our Legal Duty

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal rights, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits these changes.
2. Make the changes and the new terms of our privacy practices effective for all medical information that we keep, including information previously recorded or received before the changes.

Notice of Change To Privacy Practices:

Before we make any important changes we will change this notice and have the new notice available upon request.

3.Use and Disclosure of Your Medical Information

We have listed all of the different ways we are permitted to use and disclose medical information, however, not every use or disclosure will be listed, but we will not use or disclose your medical information for any purpose not listed below without your specific written authorization.

For Treatment:

We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to doctors, technicians or other people who are taking care of you. We may also share your medical information to other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to your insurance or directly to you and may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include evaluating the performance of employees, measuring and improving quality, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use your medical information for the following purposes.

Notification:

We may use or disclose your medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share the information about your location, general condition, or death. If you are present we will give you the opportunity to give or refuse permission, if possible before we share any information. In case of an emergency, and you are not able to give or refuse permission, we will use our professional judgment and share only the health information that is necessary for your health care. We will also use our professional judgment to make decisions about allowing someone else to pick up any medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share your medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one our affiliated fundraising foundations to contact you for fundraising purposes only. We will limit our use and sharing to information that describes you in general and not personal as well as the terms and dates of your health care. We will also provide you with a description on how you may choose not to receive any future fundraising communications.

Research in Limited Circumstances:

We may use your medical information for research purposes in where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

We may share medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization to help them carry out their duties.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use medical information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may use or disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances. Under limited circumstances, such as a court order, warrant, or a grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning medical information of a suspect, fugitive, material witness, and crime victim or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. The Food and Drug Administration for purposes of reporting events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or possible victim of other crimes. We may share your medical information to prevent a serious threat to your health or safety or the health or safety of others. When necessary we may share your medical information to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
When authorized or necessary we may disclose medical information to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, administrative, civil, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
We may disclose medical information to law enforcement officials under certain circumstances. These include reporting required by certain laws (reporting certain types of wounds), pursuant to certain court orders or subpoenas, reporting limited information concerning identification and location at the request of a law official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use your information for the purposes of sending you postcards, reminder calls or texts reminding you of your appointments.

Alternative and Additional Medical Services:
We may use your medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend alternative treatments.

4. Your Individual Rights

You Have The Right To:

1. Get copies or look at certain parts of your medical information. You must make the request in writing and you may request that we provide copies in a format other than photocopies and we will try to use the format you requested unless it is not practical for us to do so. There may be charges for copying and for postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates have shared your medical information for purposes other than treatment, payment, health care operations or other specified exceptions.
3. Request to place additional restrictions on our use or disclosure of your medical information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request in writing that we communicate with you about your medical information by different means or to different locations.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons, and provide you with a written explanation. If we accept your request we will make reasonable efforts to tell others of the change and to include the changes in any future sharing of that information.

Questions And Complaints

If you have any questions or if you believe that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. You may submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address and not retaliate in any way if you choose to file a complaint.

Signature Below Is Acknowledgement That You Understand And Have Received This Notice Of Your Privacy Practices

______________________________	________________________________	Date:_____________
Patient's Name (Print)	Patient's Signature	

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

______________________________	________________________________	Date:_____________
Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	