Patient Introduction Card

Date: _____

Name_____

Address_____

City _____, State_____ Zip_____

E-mail Address: _____

Phone (Cell) _____

Phone (Home) _____

Sex: M/F Status: Single/ Married/ Divorced/ Wid

Ethnicity: _____

Patient S.S. # _____

Date of Birth _____

Occupation_____

Employer_____

Address_____

_____

Work Phone_____

Referred to this office by: _____, Primary Care Physician: _____

I may be informed by Dr. Chris Oliver that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness. I authorize Dr. Oliver to perform such radiographic examinations as necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem or illness.
Patient's Signature: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below.
Patient's Signature: _____

INSURED'S OR AUTHORIZED SIGNATURE. I authorized payment of medical benefits to Dr. Chris Oliver of Complete Health Chiropractic and Acupuncture/ Oliver Chiropractic and Acupuncture for services performed.
Patient's Signature: _____

I understand and agree that, regardless of my insurance, I am responsible for the balance on my account for the professional services rendered. I also understand that if at any time default occurs on my account I will be not only responsible for the total balance due but also any reasonable attorney fees, address searches as well as a 5% per month interest rate. I certify the information I have provided in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my health status. **Patient Signature**: _____

The best of my knowledge, I am NOT pregnant, and Dr. Oliver has my permission to x-ray me.
Patient's Signature: _____

Informed Consent

You have the right to be informed about your condition and the possible options for treatment. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care. When a patient seeks our chiropractic care it is important for doctor and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment can be a specific thrust or relaxing the muscles, ligaments, tendons there by regaining normal spinal position and movement from fixated, misaligned joints. This allows the nervous system to work better at keeping you healthy. In addition to the many benefits of chiropractic care, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel after starting care include muscle spasm, bruising, nausea, dizziness, fatigue and soreness. Severe risks such as nerve injury, fracture, and stroke are very rare but can occur. There is no guarantee that the treatments will provide the expected or desired outcomes. Your lifestyle, including diet, exercise and stress level, will affect your results. If, at any time, you have questions or concerns regarding your treatment please contact our office. The doctor will be happy to discuss them with you. **Consent for Chiropractic Care:** I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED. I CONSENT TO RECEIVE THE CHIROPRACTIC CARE DEEMED NECESSARY BY THE DOCTOR ON THIS DATE.

Parental Consent for Minor Patient: **Patient Name: _____, DOB: _____**

Patient Signature: _____, Doctor Signature:

Patient Case History Patient Name: _____

1) What is the main problem you want to work on today: _____

Date Started: _____/_____/_____ Are The Symptoms: Constant or Intermittent

How this began:_____

Symptoms Feel : Sharp / Stabbing / Burning / Achy / Dull / Stiff / Sore / Shocking / Throbbing / Tight / Tingling / Numb

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: _____ Prescriptions/ Injection:_____

Is there any radiating (None - Pain – Numbness/ Tingling): Head: Base of Skull / Forehead / Sides-Temples R / L / Both
Leg: Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both Arm: Across Shoulder / Elbow / Hand-Fingers R / L/ Both

Circle ALL That Make Your Symptoms Worse: AM – PM – Activity – Inactivity – Bending – Computer – Drive/Travel – Exercise – Family Care – Heat – Ice – In/out of Chair – Lifting – Look Over Shoulder – Lying Down – OTC/Meds – Overuse – Personal Care – Reach Overhead – Recreation – Sitting – Sleep/Rest – Stairs – Standing – Stress – Stretching – Walk – Work – Yard Work – Nothing

2) Second problem after resolving your primary: _____

Date Started: _____/_____/_____ Are The Symptoms: Constant or Intermittent

How this began:_____

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: _____ Prescriptions/ Injection:_____

3) Third problem after resolving your primary: _____

Date Started: _____/_____/_____ Are The Symptoms: Constant or Intermittent

How this began:_____

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: _____ Prescriptions/ Injection:_____

Family Health History: _____

Personal Health History: _____

What illnesses do you take medication for now: _____

_____, Medication Allergies: _____

Any drug or alcohol addictions/ recovery: No - Yes: Explain: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic & acupuncture care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient Signature:_____, Date:_____, Doctor Signature_____

FOR OFFICE USE: Systolic: _____ Diastolic: _____ Pulse: _____ Height: _____ Weight: _____

NAME: _____, Date: _____

1) Need to call both insurances and get authorization numbers.
2) Find out if the patient's auto ins had medical pay and what max payment is for the patient.

Patient's Vehicle Insurance (Med Pay)

Ins.Co.Name_____
_____

Address _____

City/State/Zip_____

Phone _____

Policy /S.S. # _____

Claim #: _____

Prior Authorization No. _____

Contact Person: _____

Do they Medical Pay: Yes or No

What is Limit: $_____

Do they have an attorney: Yes or No

Attorney Info

Firm Name: _____

Attorney Name: _____

Address: _____

City/ State/ Zip: _____

Phone #:_____, Ext: _____

Contact Person: _____

Other Driver Auto Insurance (Liability Ins)

Ins Co Name_____

Address_____

City/State/Zip_____

Phone _____

Policy/ S.S. #_____

Claim #: _____

Prior Authorization No. _____

Contact Person: _____

Driver Name_____

Address_____

City/State/Zip_____

Name Policy Under_____

1) Remember we need a copy of the patient's personal health insurance on file.
2) Make sure we verify benefits for their health insurance.

Complete Health Chiropractic and Acupuncture, Inc.
208 Elden St., Herndon VA 20170

Dr. Chris Oliver
(703) 904-8528

Automobile Accident Questionnaire

Patient		S.S. #		Date	

Please explain in detail how your accident happened?

ACCIDENT INFO

Time present injury occurred		⎕ AM ⎕ PM		Date present injury occurred	
You were?	⎕ Driver ⎕ Passenger ⎕ Front seat ⎕ Back seat ⎕ Using seat belts ⎕ Other protective devices				
If you were not the driver of the vehicle you were in, who was?					
You were heading?	⎕ South ⎕ North ⎕ East ⎕ West	on			street or highway
Number of people in your vehicle		Were the police notified?	⎕ Yes ⎕ No	Department Name	
Did your head strike windshield or other object?		⎕ Yes ⎕ No	What?		
Was your vehicle struck from?	⎕ Behind ⎕ Front ⎕ Left Side ⎕ Right Side				
Estimated damage to your vehicle	$				
Driver of other vehicle (if any)?					
Other vehicle was heading?	⎕ South ⎕ North ⎕ East ⎕ West	on			street or highway

INJURY

Were you knocked unconscious	⎕ Yes ⎕ No	If so, for how long	
Did you feel pain immediately after the accident?	⎕ Yes ⎕ No ⎕ Later that day ⎕ Next day	When (date)?	
Where did you feel pain immediately after the accident?			
Where were you taken after the accident?			
Was treatment given?	⎕ Yes ⎕ No		

TREATMENT

Was any doctor consulted after the accident	⎕ Yes ⎕ No	Name	⎕ DC, ⎕ MD, ⎕ DO, ⎕ DDS
Doctor's Diagnosis			
What treatments were given?			
How often did you see the doctor?			
How long did you see the doctor? (days/ weeks)			

HISTORY

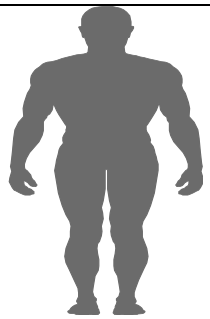
Have you ever had any complaints in the involved area before?	⎕ Yes ⎕ No	When?	
If so, what were the complaints?			
Before the injury, were you capable of working on an equal basis with others your age?	⎕ Yes ⎕ No		
Are your work activities restricted as a result of this accident?	⎕ Yes ⎕ No		
Since the injury, are your symptoms	⎕ Improving? ⎕ Getting worse? ⎕ The same?		

PLEASE CHECK ALL THAT APPLY TO YOU NOW

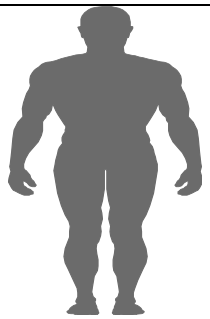
Musculoskeletal System	Genito-Urinary System	Gastro-Intestinal System	Cardio-Vascular System
⎕ Low Back pain	⎕ Bladder Trouble	⎕ Poor appetite	⎕ Chest pain
⎕ Mid back pain	⎕ Excessive urination	⎕ Excessive hunger	⎕ Pain over heart
⎕ Pain between shoulders	⎕ Scanty urination	⎕ Difficult chewing	⎕ Difficult breathing
⎕ Neck pain	⎕ Painful urination	⎕ Difficult swallowing	⎕ Persistent cough
⎕ Arm pain	⎕ Discolored urine	⎕ Excessive thirst	⎕ Coughing phlegm
⎕ Leg problems	**EYE,EAR,NOSE,THROAT**	⎕ Nausea	⎕ Coughing blood
⎕ Swollen joints	⎕ Eye strain	⎕ Vomiting Blood	⎕ Rapid heartbeat
⎕ Painful joints	⎕ Eye inflammation	⎕ Abdominal pain	⎕ Blood pressure problems
⎕ Stiff joints	⎕ Vision problems	⎕ Diarrhea	⎕ Heart problems
⎕ Sore muscles	⎕ Ear pain	⎕ Constipation	⎕ Lung problems
⎕ Weak muscles	⎕ Ear noises	⎕ Black stool	⎕ Varicose veins
⎕ Walking problems	⎕ Ear discharge	⎕ Hemorrhoids	
⎕ Spasms	⎕ Hearing loss	⎕ Liver trouble	
⎕ Broken bones	⎕ Nose pain	⎕ Gall bladder problems	
⎕ Shoulder pain	⎕ Nose bleeding	⎕ Weight trouble	
FEMALE	⎕ Nose discharge	**NERVOUS SYSTEM**	
⎕ Vaginal discharge	⎕ Difficult to breath thru nose	⎕ Numbness	
⎕ Vaginal bleeding	⎕ Sore gums	⎕ Loss of feeling	
⎕ Vaginal pain	⎕ Dental problems	⎕ Paralysis	
⎕ Breast pain	⎕ Sore mouth	⎕ Dizziness	
⎕ Lumps on the breast	⎕ Sore throat	⎕ Fainting	
PREGNANT	⎕ Hoarseness	⎕ Headaches	
HABITS	⎕ Difficult speech	⎕ Muscle jerking	
⎕ Cigarettes	⎕ Sinus	⎕ Convulsions	
⎕ Alcohol Abuse	⎕ Allergy	⎕ Forgetfulness	
⎕ Coffee or Tea	⎕ Jaw pain	⎕ Confusion	
⎕ Drug Abuse		⎕ Depression	
		⎕ Insomnia	

Draw Accident

Circle Your Pain Level
Least 1 2 3 4 5 6 7 8 9 10 **Worst**



FRONT



BACK

Mark Your Symptoms

T=Tender **P=Pain** **S=Spasm** **N=Numbness**

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between the patient that signed below and **Complete Health Chiropractic and Acupuncture (Dr. Chris Oliver)** ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, **Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider** for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the HealthCare Provider by the Patient. This Assignment is to be a complete and current transfer of Patient's right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all of the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of the Health Care Provider, to prosecute said causes(s) of action either in Patient's name or in the Health Care Provider's name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the

Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Provider's right to demand payment from the Patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the HealthCare Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect. Witness the following signatures and seal as of the indicated date:

Patient: _____. Print: _____, Date: _____

Health Care Staff: _____, Print: _____, Date: _____

Health Care Provider: Dr. Chris Oliver - OR - Health Care Provider: Associate or IC of Complete Health Chiropractic and Acupuncture

Dr. Chris Oliver
Chiropractic Physician
Trained in Acupuncture

Patient Agreement

I have executed the right under the Hitech-HIPAA Omnibus Rule of September 23, 2013 restricting disclosure of my health insurance information for the purpose of billing my health insurance for the medical expenses occurred from this accident, unless there is an outstanding balance after billing the med pay and liability insurance. I hereby direct Complete Health Chiropractic and Acupuncture (Dr. Oliver) to bill the medical expenses occurred from this accident directly billed to the med pay and liability insurance. In accordance with Virginia Code 38.2-2201 and in accordance with the attached fully executed Assignment of Benefits (AOB) authorizing and directing all payments to be made directly to Complete Health Chiropractic and Acupuncture (Dr. Oliver).

Signature of Patient: _____, Date: _____

Staff: _____, Date: _____

HIPAA Notice of Privacy Practices

Oliver Chiropractic and Acupuncture, LLC
208 Elden St.
Herndon, VA 20170

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Privacy Officers, Dr. Christopher Oliver at (703) 904-8528.

Our Obligations: We are required by law to: • Maintain the privacy of protected health information • Give you the notice of your legal duties and privacy practices regarding health information about you • Follow the terms of our notice that is currently in effect **How We May Use and Disclose Health Information:** Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer. **Treatment**. We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. **Payment**. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment. **Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities. **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you. **Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes. **Special Situations:** As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment. **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract. **Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation. **Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. **Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness. **Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law. **Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. **Lawsuits and Disputes.** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. **Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime. **Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties. **National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. **Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution. **Your Rights** You have the following rights regarding Health Information we have about you: **Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer. **Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Clinical Summary Report (CCR) Disclaimer: I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Oliver Chiropractic and Acupuncture, LLC to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review. **Changes to This Notice** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner. **Complaints** If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint. By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature **Date**