HEART IN HAND CHIROPRACTIC

Excellent Compassionate Healthcare

Athena Paradise, DC

Today's Date:

Registration Form

☐ New Patient ☐ Updated Info

Account #: **PATIENT INFORMATION** ☐ Chiro ☐ Naturo ☐ Homeo

Last Name: First Name: Middle Initial: Birth Date: Age: Gender: ☐ M ☐ F ☐ Other

Nickname or Preferred Name: Driver's License #/State: Marital Status: ☐ Si. ☐ Mar. ☐ Partner ☐ Div. ☐ Sep. ☐ Wid.

Street Address: City: State: Zip:

Preferred Phone #: Phone Type: ☐ Home ☐ Work ☐ Cell Secondary Phone #: Phone Type: ☐ Home ☐ Work ☐ Cell

E-mail Address: Would you like to receive our periodic newsletters and updates? ☐ Yes, by e-mail ☐ Yes, by regular mail ☐ No thanks

Employer: Occupation: Hours/Week:

How did you hear about our clinic? ☐ Location ☐ Family/Friend ☐ Insurance Plan ☐ Physician ☐ Seminar or event ☐ Internet/Website ☐ Other:

Name of person who referred you to us:

PATIENT HEALTH INSURANCE INFORMATION **(for chiropractic patients only)**

(Please give your insurance card to the receptionist. If you have a secondary insurance you would like us to bill, please notify receptionist)

Name of Insurance Plan: Address: City: State: Zip:

Subscriber's Name: Subscriber's Social Security #: Birth Date:

Group #: Policy #: Co-pay: Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

MOTOR VEHICLE / WORKER'S COMPENSATION INSURANCE INFORMATION

☐ MVA ☐ Work Comp.

Name of Primary Insurance Plan: Address: City: State: Zip:

Claim Representative Name: Phone #: Attorney's Name: Phone #:

Date of Injury: Claim #: Injured Body Part(s):

Name of Employer at Time of Injury: Employer Address:

IN CASE OF EMERGENCY

Name of Local Friend or Relative: Relationship to Patient Phone #:

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance per the credit policies of Portland Natural Health. I also authorize Portland Natural Health or the insurance company to release any information required to process my claims.

Signature: ______________________________ **Date:** ______________

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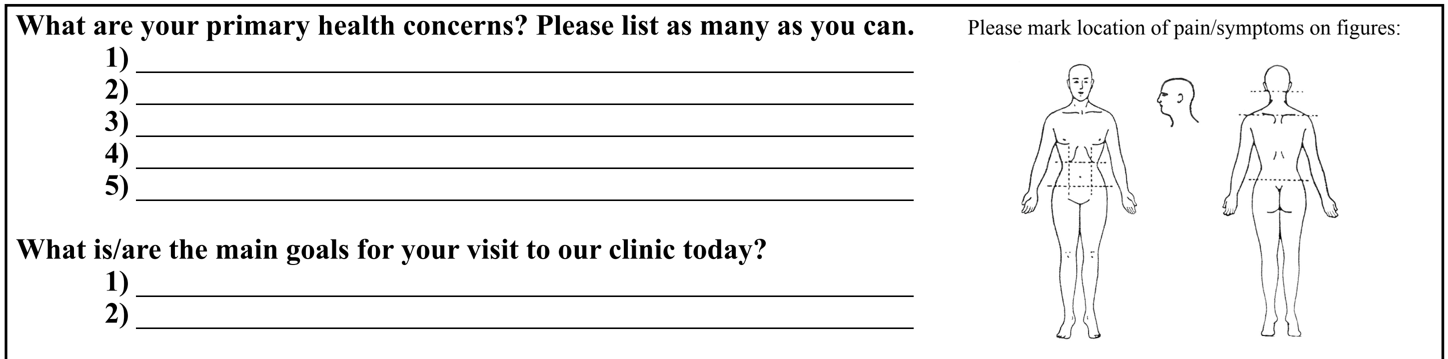
Patient Health History

Patient's Name: ______________________ **Date:** __________ **Date of Birth:** __________

Chiropractic healthcare is possible only when the physician completely understands the patient's physical, mental and emotional conditions. The information that you provide helps us better understand your needs and how we can help you reach your health goals. Please print legibly and answer all questions. Also, please mark anything you may have questions about.

< ALL INFORMATION ON THIS QUESTIONNAIRE IS CONFIDENTIAL >



What are your primary health concerns? Please list as many as you can.

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

What is/are the main goals for your visit to our clinic today?

1) ______________________
2) ______________________

Please mark location of pain/symptoms on figures:

HEALTHCARE

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, please list your current providers (with contact information, if available): ______________________

____

If no, where and when did you last receive medical care? ______________________

MEDICATIONS AND/OR SUPPLEMENTS

Do you take or use any of the following:

☐ Pain relievers (e.g. Aspirin, Ibuprofen) ☐ Sleeping pills ☐ Thyroid medication ☐ Laxatives
☐ Diet pills, appetite suppressants ☐ Antibiotics ☐ Tranquilizers ☐ Antacids
☐ Cortisone (cream or pills)

Please list any prescription medication, over-the-counter medication, vitamins, or other supplements you are taking. Include dosage and frequency of consumption.

1) ______________________ 5) ______________________
2) ______________________ 6) ______________________
3) ______________________ 7) ______________________
4) 8)

ALLERGIES AND/OR ALLERGIC REACTIONS

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: ______________________

____

34360 Hwy 101 S., Cloverdale, OR 97112 Tel: 503-936-6182 • heartinhandchiropractic@gmail.com • heartinhandchiropractic.com

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GENERAL INFORMATION

Height: ________________________ Weight (lb): _________________ Weight one year ago (lb): _________________
Maximum weight (lb): _____________ When? __________ Are you happy with your current weight? ☐ Yes ☐ No

Energy level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is there any condition (physical, mental, emotional) from which you feel that you have not fully recovered?
____

PAST MEDICAL HISTORY

What hospitalizations or surgeries have you had?
____
____

What diagnostic imaging studies have you had?

☐ X-ray ☐ Ultrasound ☐ Bone density scan ☐ Electrocardiogram (EKG)
☐ CT scan ☐ Colon-/sigmoidoscopy ☐ Mammogram ☐ Electroencephalogram (EEG)
☐ MRI ☐ Other:

FAMILY HISTORY

Do you have a family history of any of the following? When answering, please include your parents, brothers/sisters, and grandparents, if known. Please check all that apply.

☐ Alcoholism/addiction
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autoimmune condition
☐ Cancer (type? _____________)
☐ Celiacs
☐ Diabetes
☐ Epilepsy
☐ Gallbladder disease
☐ Headaches/migraines
☐ Heart disease
☐ High blood pressure
☐ Kidney disease
☐ Liver disease
☐ Mental health concern
☐ Skin condition
☐ Stroke
☐ Thyroid problem
☐ Other (please list below)

Is your father living? ☐ Yes; his age: _____ ☐ No; age at time of death: _____ Cause of death: _______________
Is your mother living? ☐ Yes; her age: _____ ☐ No; age at time of death: _____ Cause of death: _______________
Do you have siblings? If so, how is their health? ____

Please list other significant family medical history not listed above:
____

CHILDHOOD ILLNESSES

Please indicated whether you have/had any of the following conditions as a child/adolescent:

☐ Diphtheria ☐ Measles ☐ Rheumatic fever ☐ Scarlet fever
☐ German measles ☐ Mumps ☐ Other:

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REVIEW OF SYSTEMS

< Please check the box if you're experiencing condition/symptom currently or have experienced it in the last 6 months >

Skin:

- ☐ Acne, boils
- ☐ Color changes
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Lumps
- ☐ Rashes

Head:

- ☐ Hair loss
- ☐ Head injury
- ☐ Headaches/migraines
- ☐ Jaw/TMJ problems

Ears:

- ☐ Earaches
- ☐ Excess wax
- ☐ Impaired hearing
- ☐ Ringing

Eyes:

- ☐ Blurriness
- ☐ Cataracts
- ☐ Color blindness
- ☐ Double vision
- ☐ Eye pain/strain
- ☐ Glasses/contacts
- ☐ Glaucoma
- ☐ Spots in vision
- ☐ Tearing/dryness
- ☐ Vision changes

Last eye exam: _________

Nose & Sinuses:

- ☐ Hay fever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Stuffiness

Mouth & Throat:

- ☐ Copious saliva
- ☐ Dental cavities
- ☐ Dry mouth
- ☐ Frequent sore throat
- ☐ Gum problems
- ☐ Hoarseness
- ☐ Jaw clicks
- ☐ Teeth-grinding

Neck:

- ☐ Lumps
- ☐ Goiter
- ☐ Pain or stiffness

Respiratory:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Pain with breathing
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Sputum
- ☐ Tuberculosis
- ☐ Wheezing

Cardiovascular:

- ☐ Angina
- ☐ Ankle swelling
- ☐ Blood clots
- ☐ Chest pain
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Murmur
- ☐ Palpitations
- ☐ Rheumatic fever

Peripheral Vascular:

- ☐ Cold hands/feet
- ☐ Deep leg pain
- ☐ Easy bruising
- ☐ Varicose veins

Musculoskeletal:

- ☐ Arthritis
- ☐ Broken bones
- ☐ Joint pain/stiffness
- ☐ Muscle pain
- ☐ Muscle spasms
- ☐ Osteoporosis
- ☐ Weakness

Gastrointestinal:

- ☐ Abdominal pain/cramps
- ☐ Belching
- ☐ Black stool
- ☐ Blood in stool
- ☐ Change in appetite
- ☐ Change in thirst
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Jaundice (yellow skin)
- ☐ Liver disease
- ☐ Nausea/vomiting
- ☐ Passing gas
- ☐ Trouble swallowing
- ☐ Ulcer

# of bowel mvmts/day: ___________________

Immune:

- ☐ Frequent colds
- ☐ Ongoing infections
- ☐ Reactions to vaccines
- ☐ Slow wound healing
- ☐ Swollen glands

Urinary:

- ☐ Difficulty starting
- ☐ Frequent infections
- ☐ Frequency at night
- ☐ Increased freq.
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Splitting of stream
- ☐ Unable to hold

Endocrine:

- ☐ Brittle nails
- ☐ Cold intolerance
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Fatigue after meals
- ☐ General fatigue
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Night sweats
- ☐ Seasonal depress.

Neurological:

- ☐ Fainting
- ☐ Loss of memory
- ☐ Muscle weakness
- ☐ Numbness/tingling
- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures
- ☐ Vertigo or dizziness

Mental/Emotional:

- ☐ Anxiety
- ☐ Depression
- ☐ Memory problems
- ☐ Mood swings
- ☐ Poor concentration
- ☐ Tension/stress

REVIEW OF SYSTEMS (cont.)

Male Reproduction:

Date of last physical exam:

____

Date of last STD/STI testing:

____

- ☐ Decreased libido
- ☐ Discharge or sores
- ☐ Hernias
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Prostate problems
- ☐ Sexual difficulty

Sexual orientation:

____

- ☐ Sexually active currently
- ☐ Sexually active in past
- ☐ Sexually transmitted infection
- ☐ Testicular pain
- ☐ Testicular masses

Female Reproduction/Breasts:

Age of first menses:

____

Age of last menses (if menopausal):

____

- ☐ Bleeding between periods
- ☐ Breast lump(s)
- ☐ Breasts tender
- ☐ Cervical dysplasia
- ☐ Clotting
- ☐ Currently pregnant

# of pregnancies: __________
# of live births: __________
# of miscarriages: __________
# of abortions: __________

Date of last annual exam:

____

Date of last STD/STI testing:

____

- ☐ Decreased libido
- ☐ Difficulty conceiving
- ☐ Discharge or sores

Female Reproduction (cont.)

- ☐ Do breast self-exams
- ☐ Endometriosis
- ☐ Heavy flow
- ☐ Irregular cycles
- ☐ Itching
- ☐ Light flow
- ☐ Menopausal symptoms

Menstrual cycle:

Length of cycle: __________
Duration of bleeding: ________
Date of last period: __________

- ☐ Nipple discharge
- ☐ Ovarian cysts
- ☐ Painful periods
- ☐ PMS
- ☐ Previous abnormal paps
- ☐ Sexual difficulty or pain

Sexual orientation:

____

- ☐ Sexually active currently
- ☐ Sexually active in past

Type of birth control (if appl.):

____

WELLNESS

How satisfied are you with various aspects of your life? The following are important aspects of health. Please rate yourself in terms of satisfaction and dissatisfaction. (0 = very dissatisfied or stressed; 10 = very satisfied or comfortable).

Friends & family:	0	1	2	3	4	5	6	7	8	9	10
Physical environment:	0	1	2	3	4	5	6	7	8	9	10
Health:	0	1	2	3	4	5	6	7	8	9	10
Career:	0	1	2	3	4	5	6	7	8	9	10
Relationships/romance:	0	1	2	3	4	5	6	7	8	9	10
Recreation & fun:	0	1	2	3	4	5	6	7	8	9	10
Money:	0	1	2	3	4	5	6	7	8	9	10
Personal growth/spirituality:	0	1	2	3	4	5	6	7	8	9	10

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HABITS

< Please check the boxes to indicate current habits and habits for the last 6 months. A check = “Yes” >

Sleep:

- ☐ Average 6-8 hours of sleep/night
- ☐ Awaken feeling rested
- ☐ Sleep well

Eating & Drinking:

- ☐ Drink coffee
- ☐ Drink cola or other sodas
- ☐ Drink green or black tea
- ☐ Eat out often
- ☐ Eat refined sugar
- ☐ Eat three meals a day
- ☐ Go on diets often

Substance Use:

- ☐ Drink alcoholic beverages
- ☐ Smoke/chew tobacco
- ☐ Use recreational drugs

Have you had or been treated for:

- ☐ Alcoholism
- ☐ Drug dependence
- ☐ Eating disorder

☐ Have you smoked previously?
If yes, # of years: ___________
# of packs per day: ___________

Relationships:

- ☐ Have a history of abuse
- ☐ In a supportive relationship

Work & Recreation:

- ☐ Enjoy your work
- ☐ Read

If yes, how many hours? _____

- ☐ Spend time outside
- ☐ Take vacations
- ☐ Watch television

If yes, how many hours? _____

Exercise:

Do you exercise? ☐ Yes ☐ No If yes, what kind? ___________________________
With exercise, you feel: ☐ Better ☐ Fatigued How often do you exercise? ___________________

Spirituality & Relaxation:

Do you have a religious or spiritual practice? ☐ Yes ☐ No If yes, what? _______________
Do you have stress management practices? ☐ Yes ☐ No If yes, what? _______________
Main interests and hobbies? ____

Diet:

Please list what you had for breakfast, lunch, dinner, and snacks in the last 24 hours:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Fluids: ____

Do you have any dietary restrictions and why? _________________________________

THERAPEUTICS

What therapies interest you?

- ☐ Chiropractic
- ☐ Counseling
- ☐ Homeopathy
- ☐ Hydrotherapy
- ☐ Nutrient injection therapy
- ☐ Other:

What changes are you willing to make improve your health?

- ☐ Alcohol reduction/cessation
- ☐ Dietary changes
- ☐ Exercise
- ☐ Recreational drug cessation
- ☐ Sleep patterns
- ☐ Smoking cessation

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Consent Form

Dear New Patient,

Chiropractic examination and therapeutic procedures (which may include: physical examination, spinal and extremity manipulation, manual muscle therapy, physiotherapy, laboratory tests, therapeutic nutrition, botanical medicine, and lifestyle counseling) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of J gctv"kp"J cpf"Ej ktqr tcevke to inform our patients about them. Depending on the type of care received, these complications may include, but are not limited to, soreness, inflammation, soft tissue injury and/or bruising, dizziness and/or fainting, burns, infiltration, allergic reactions to prescribed supplements and herbs, and temporary worsening of symptoms. More serious complications are extremely rare. These include: injury to the arteries of the neck (which may be associated with stroke and serious neurological impairment), injuries to the spinal discs, spinal fractures, deep tissue injury, and pneumothorax. The doctor cannot be expected to anticipate all risks and complications but will always exercise judgment based on the facts known and the patient's best interest. If potential complications are not explained to your satisfaction, please ask your physician for more information.

I have read and understand the above statements regarding possible treatment side-effects. I also understand that, through my treatment, there is no guarantee of a specific cure or result.

Patient / Guardian's Signature: ____ **Date:** ____________

Please read the following carefully and initial each statement:

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, artificial joint(s), etc.), I should discuss this with the doctor providing me chiropractic care.

_____ I understand that I play an important role in my own healthcare. Just as a patient can choose to discontinue care at any time, Portland Natural Health reserves the right to terminate a doctor/patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_____ I understand that the practitioners of Portland Natural Health may terminate the doctor/patient relationship if I miss 3 scheduled appointments without providing 24 hours advance notice of my cancellation or if I behave inappropriately toward practitioners or clinic staff.

For women only:

_____ I understand that if I am pregnant, or if there is reason to suspect that I might be pregnant, I will inform my doctor before they provide me with chiropractic care.

By signing this form, I affirm that I have provided true and complete information. I hereby authorize Portland Natural Health to provide chiropractic services to me.

Patient / Guardian Signature: ____ **Date:** ______________

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize any chiropractic treatment deemed advisable for:

(patient's full name) ____ **(patient's date of birth):** ___________

if I or any other legal guardian is not available when the child is brought to the clinic for treatment.

Signature of Parent or Guardian: ___________________________ **Witnessed by:** ___________________________

Chiropractic Financial Policy

GENERAL INFORMATION

In exchange for chiropractic services at Heart in Hand Chiropractic, we accept payment via cash, check, and Visa or Mastercard. Checks may be made payable to "Heart in Hand Chiropractic". If necessary, payment plans can be arranged on an individual basis. Please note that all payments are due at the time of service, unless special arrangements have been made prior to the visit. For those patients with health insurance and chiropractic benefits, all co-pays will be due at the time of service, once your insurance coverage has been verified and we have determined what your responsibility is. Also, as a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that, if there is a discrepancy between what's billed to your insurance carrier and what's reimbursed to the practitioners of of Portland Natural Health, we will let you know as soon as possible. **Please note that the patient is responsible for this balance**. Please also note that we will not get involved with any dispute between you and your insurance carrier. If you have a credit balance, we will reimburse you after payment has been received. All supplies, supplements, and items from the medicinary must be paid for at the time they're received by the patient. Please note that the patient is responsible for the timely payment of their account.

WORKER'S COMPENSATION CLAIMS

All expenses from worker's compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, you are responsible for the prompt payment of your account.

PERSONAL INJURY / MOTOR VEHICLE ACCIDENTS

All expenses from personal injury and auto accident cases will be billed to your auto insurance company, providing the appropriate paperwork has been filled out and a claim filed. Please note that we do not do third party billings to other insurance companies. If you choose not to file a claim with your auto insurance company, or you are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service. In most instances, supplements, lab work, and some supplies may not be covered by insurance companies and *must* be paid for at the time they're received. Should the insurance company cover these items, we will reimburse you for the amount paid.

***

***Please note: an appointment that is missed or cancelled without at least 24 hours advance notice will result in a $50 charge (insurance carriers will not cover this fee).** A missed appointment is recorded when a patient fails to arrive within 10 minutes after the scheduled meeting time. If you are unable to attend, kindly notify us and we'll be happy to re-schedule your appointment. Also, for all returned checks, there will be a charge of $25 applied. A finance charge may be applied for accounts over 60 days, unless a payment plan has been arranged.

I have read, understand, and agree with the above financial policy, and I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, private insurance and all other health plans, to Heart in Hand Chiropractic, 2125 SE Oak St., Portland, OR 97214.

Patient / Guardian's Signature: ____ **Date:** ___________

Notice of Privacy Practices (HIPAA)

Please read this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, and/or health care operations, and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health and/or condition and related health services.

Your PHI may be used and/or disclosed by your physician, their office staff, and others outside the office that are involved in your care and treatment for the purposes of providing healthcare services to you, paying your healthcare bills, supporting the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, and/or manage your healthcare and any related services. This includes the coordination and/or management of your healthcare with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you; or, your PHI may be provided to a physician to whom you have been referred to ensure that that physician has the necessary information to diagnose and/or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. A bill will be sent to you or your third party payor (i.e. your insurance company). The information on or accompanying the bill may include information that identifies you, as well as your diagnoses, procedures rendered, and healthcare providers and supplies used. We may also contact your insurance company to determine if they will pay for your medical care as part of their certification process.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

As required by law: We may use or disclose your PHI to the following entities without your authorization. These entities include: the Food and Drug Administration; public health and/or legal authorities charged with disease prevention; correctional institutions; worker's compensation and personal injury agents; organ and tissue donation organizations; military command authorities; health oversight agencies; and funeral directors, coroners, and medical examiners.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization—in writing—at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The following is a statement of your rights with respect to your PHI:

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law(s) that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Please note that your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional

OUR DUTIES & RIGHTS

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you can ask that we use an alternative address for billing purposes.

You have the right to request an amendment of your PHI. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to obtain an accounting of the PHI disclosures we have made.

You have the right to obtain a paper copy of this notice from us, upon request.

Questions and complaints: If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Our duties consist of the following. We must:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you have made to communicate health information by alternative means or at alternative locations

We have the right to:

- Change our Notice of Privacy Practices and the terms of this notice at any time, provided the changes are permitted by law
- Make the changes in our Notice of Privacy Practices effective for all medical information we keep, including information previously created or received before the changes (note: before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request)

***

I have read and understand the contents of this document.

Print Name: ____

Patient / Guardian's Signature: ______________________________ **Date:** ____________