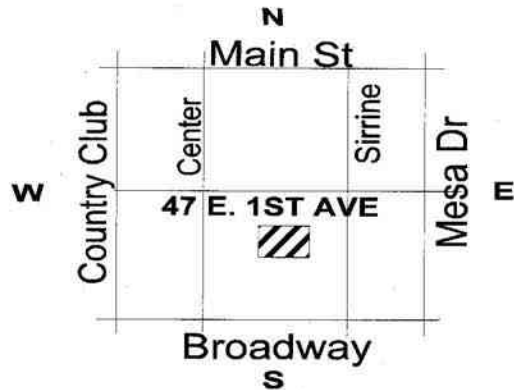


DR. MICHAEL HAFKEY, R.N., B.S.N., D.C.

47 E. 1ST AVENUE • MESA, ARIZONA 85210-1446 • OFFICE: 480-668-8780 • FAX: 480-668-8787

FAX COVER PAGE

ATTN: NEW PATIENT



Please fill out all the forms completely, sign and date by the X's. Please bring your insurance card, and all the forms with you to your next appointment.

You can email me at drhafkey@cox.net, or visit my website at <http://www.MesaChiro.com>
Thanks, and see you soon.

Confidentiality Statement

This Electronic Message contains information from HAFKEY CHIROPRACTIC, created by DR MICHAEL HAFKEY, and is confidential or privileged. The information is intended to be for the use of the individual or entity named above. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this message is prohibited. If you have received this electronic message in error, please notify us immediately by telephone at (480) 668-8780.

OFFICE HOURS

Mon. Wed. Fri.

(10-1 and 2-6)

Tues. & Thurs.

(10-1 and 2-7)

Saturdays

By Appointment

WELCOME

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City HT- WT- State Zip

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

your Email Address: _____ @ _____

INSURANCE

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, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Michael Hafkey 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____
Responsible Party Signature

_____ X _____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

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) _____

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

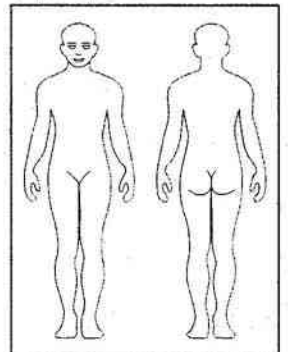
How often do you have this pain? _____

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

MARK BELOW ↓



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:

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

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking _____ Packs/Day _____ <input type="checkbox"/> Alcohol _____ Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks _____ Cups/Day _____ <input type="checkbox"/> 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	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
X		
Pharmacy Name _____		
Pharmacy Phone _____		

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____
City: _____ State: _____ Zip: _____ Telephone: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

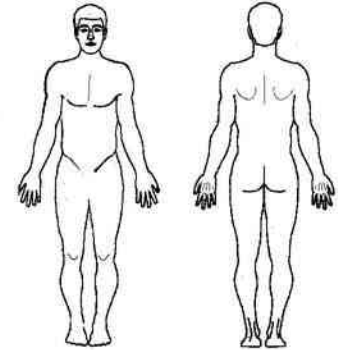
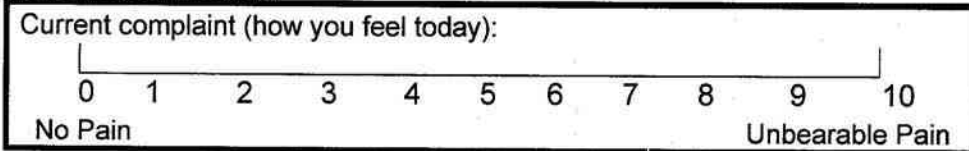
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain
 Other _____

Is this? Work Related Auto Related N/A

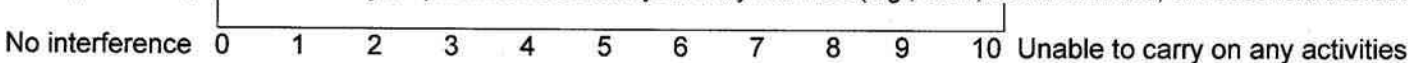
Date Problem Began: _____

How Problem Began: _____



How often are your symptoms present?
(Intermittent) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (date) _____
- Corticosteroid Use (cortisone, prednisone, etc.)
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (explain) _____
- _____
- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (explain) _____
- _____
- _____

- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # weeks _____
- Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries _____
- _____
- Medications: _____
- _____
- _____

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ Date: _____

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47 E. 1ST AVENUE • MESA, ARIZONA 85210-1446 • OFFICE: 480-668-8780 • FAX: 480-668-8787

ACCIDENT HISTORY QUESTIONNAIRE

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of car: _____
7. What was the approximate damage done to your car? _____

8. Visibility at time of accident: poor fair good other:
9. Road conditions at time of accident: icy rainy wet clear dark
 other (describe): _____
10. Where was your car struck? right left rear front side
 other (describe): _____
11. Type of Accident: Head-on collision Broad-side collision Front Impact
 Rear-end car in front Non-collision
12. Describe in your own words what happened to you upon impact: _____

13. Did you see the accident coming? yes no
14. Did you brace for impact? yes no
15. Were seatbelts worn? yes no
16. Were shoulder harnesses worn? yes no
17. Does your car have headrests? yes no
18. If yes, what was the position of those headrests compared to your head before the accident?
 Top of headrest even with **bottom** of head
 Top of headrest even with **top** of head
 Top of headrest even with **middle** of neck
19. Was your car braking? yes no
20. Was your car moving at the time of the accident? yes no
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left
 Head straight forward Other: _____
24. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____
25. As a result of the accident you were: Rendered unconscious
 Dazed. circumstances vague Other: _____

ACCIDENT QUESTIONNAIRE

Date: _____

Injured Party: _____

Member ID Number: _____

Date of Occurrence: _____

Dear _____:
(Patient)

In order to update our records and complete claims processing we are asking that you complete this questionnaire concerning your injuries.

Thank you for assisting our efforts in providing quality service.

Briefly describe the cause of injury: (e.g., location of accident/how it happened)

Name of other Insurance Company (e.g., auto, homeowners, workers comp)

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Policy Holder's Name: _____ Policy # _____ Claim # _____

If you have retained an attorney, please provide the following information:

Attorney's Name: _____

Address: _____
(Street) (City) (State) (Zip)

Telephone Number: (____) _____

Identity of other parties who may be responsible for the injuries:

Name: _____ Telephone Number: (____) _____

Address _____

Name of Insurance Company: _____ Telephone Number: (____) _____

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Policyholder's Name: _____ Policy Number: _____

Adjuster's Name: _____ Claim Number: _____

Date: _____ Member's Signature: X _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Date of accident _____ Hour _____ AM PM ACCIDENT FORM

Location _____

How did accident occur? Auto Collision On-The-Job Other

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? Yes No

Did he (they) recommend care at our office? Yes No

If Auto accident, were you the Driver Passenger Pedestrian

If Auto collision were you struck from Behind Right Side Left Side

Front Auto was parked

Did your car strike the other(s) involved? Yes No

Did the other car strike yours? Yes No

Were you sitting in the Front or Back seat of the auto?

Auto was carrying _____ people.

Immediately following the accident you went:

home to the hospital to another doctor's office to this office.

As a result of the accident were traffic citations issued to you? Yes No

To the driver of the other car? Yes No

List the extent of the injuries as you know them: _____

Did you require Post-Accident Hospitalization? Yes No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | |
|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Cold Sweats |
| | <input type="checkbox"/> Fever | <input type="checkbox"/> Other |

Symptoms other than above: _____

Have you lost any days of work? Yes No Dates: _____

Insurance Companies Involved: _____

My Company _____

Company of Person Responsible for injuries _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? Yes No

INFORMED CONSENT

Patient Name: X Date: X

As a patient in my office, you have the legal right to know of the type of treatment we will use, any complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these and treatment cannot be given until you understand these issues and sign this form. If you have any questions after reading this form, please ask me or my staff members.

The primary treatment used by doctors of chiropractic is the **spinal adjustment** to reduce spinal subluxations (slight dislocations or misalignments of the spinal joints). I will use that procedure to treat you as well as use other common secondary treatments such as physical therapies and modalities.

- **The nature of the chiropractic adjustment:** I will use my hands upon your spine in such a way as to move your spinal joints to restore normal joint play. This procedure may cause an audible "pop" or "click" similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, and this usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there are other non-forceful types of spinal adjustments that may be used. If, from previous experiences, you prefer non-traditional types of spinal adjustments, please inform the staff beforehand.
- **The material risks inherent in a chiropractic adjustment:** While serious complications occur only 1-2 times per million adjustments, there is a slight risk, such as fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness or soreness following the first few days of treatment, which is considered normal.
- **The probability of those risks occurring:**
 - Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, we will take special efforts to adjust your spine carefully.
 - Stroke has been the subject of tremendous disagreement within the health professions. Usually there is an underlying, pre-existing vascular condition like atherosclerosis that contributes to a stroke resulting after a neck adjustment. Some types of manipulation of the neck have been associated with other injuries to the arteries in the neck leading to a stroke in rare instances along the lines of 1 per 3 million. Mortality from spinal adjustments is 3 per 10 million.
 - Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary if symptoms are not improved within 4 weeks. If need be, we will refer you to a neurosurgeon or for an MRI exam. These problems occur so rarely that there are no available statistics to quantify their probability.
- **Ancillary treatments:** In addition to chiropractic adjustments, I intend to use the following treatments if necessary to control your pain or to stabilize your spinal weakness:
 - **Ice or hot packs:** We may use both heat and ice packs, and recommend ice for home use. Both may irritate or burn your skin if over-used more than 20 to 30 minutes without a layer of clothing between your skin and the ice/heat pack. The results are temporary and occur so rarely that there are no available statistics to quantify their probability.
 - **Electro-therapy:** This modality consists of a mild electrical current which sends a massage-type action through the muscles and nerves to relax constricted muscles, to block pain impulses, to reduce swelling and to facilitate healing in muscles and ligaments. There are no known side-effects.

- **Alternative Medical Treatments & Risks:** Other treatments are available for your condition include:
 - **Self-administered over-the-counter NSAIDs** may cause gastro-intestinal problems in 1,000 to 4,000 people per one million, and reportedly 16,500 die annually from their use.
 - **Prescription muscle relaxants and pain-killers** can produce undesirable side effects and dependence. They can also make you quite drowsy and impair your motor skills.
 - **Hospitalization and bed rest** bears the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% a day. It is also very expensive and research has shown bed rest has no benefit in helping back pain patients, in fact, it may contribute to a worsening condition.
 - **Back or Neck Surgery** have many risks: Infections; allergic reactions; disfiguring scar; severe loss of blood; loss of function or any limb or organ paralysis; paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder, bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; injury to esophagus, trachea or lungs; hoarseness; spinal fluid leak; unstable spine requiring fusion; failure of fusion; injury to GI or GU tract; recurrence of disc problems or scar tissue formation with progressive weakness or numbness; paralysis. In addition, other risks associated with anesthesia are loss of teeth; corneal abrasions; or abdominal reactions to anesthetic agents. Serious neurological complications from neck surgery are 15,600 per million; mortality rates are 6,900 per million.

- **The Risks and Dangers to Remaining Untreated:**
 - Remaining untreated allows the formation of adhesions and reduces joint motion which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage, muscular weakness and/or an increase of spinal distortions may progress if your spinal problem goes untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. IF YOU HAVE UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me [] the above explanation of the chiropractic care and related treatments. I have discussed it with the doctor and/or staff of this office and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the health plan recommended. Having been informed of the nature and risks of chiropractic care, I hereby give my consent to be treated.

Name: X _____

Dated: _____

Signature: X _____

Signature of Parent or Guardian: _____

Witness: _____

Printed name: _____

Signature: _____

See Reverse Side

HIPAA Notice of Privacy Practices

Dr Michael Hafkey
47 E 1st Avenue
Mesa AZ 85210
480-668-8780

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

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

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

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

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information 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 protected health information 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 protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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, at any time, in writing, 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.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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 requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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 receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: X Signature X Date _____

See REVERSE SIDE