APPLICATION FOR CARE

BASIC INFORMATION					
Today's date:					
Last name:		First name:			Middle:
Marital status: Single Married. Divorced Widow Separated			Spouse's name:		# Of children:
Date of birth:	Age:	Sex:	Social Security No.:		
Address:			City:		State:
Zip code:	Home phone #:		Cell #:	Work #:	
Email address:			How did you hear about our office?		
Emergency Contact name:		Home phone #:		Cell #:	
Primary Care physician's name:					

WORK INFORMATION		
Occupation:	Employer:	
Job Description:		Years on job:

INSURANCE INFORMATION / PAYMENT METHOD		
Do you have Medicare: ☐ Yes ☐ No	Medicare Alternative: ☐ Yes ☐ No	Do you have MaineCare or Q.M.B.: ☐ Yes ☐ No
How do you plan to pay for today's visit? Options: Cash Check Visa / Master Card CareCredit		

WORKERS COMP / PERSONAL INJURY / DISABILITY
Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the Job ☐ Auto Collision ☐ Personal Injury ☐ Other
Has the accident been reported? ☐ Yes ☐ No ☐ To Employer ☐ Auto Carrier ☐ Other _____
Have you retained an attorney? ☐ Yes ☐ No Name / Address _____
Are you now or have you ever been disabled / impaired? (Military or Work)? ☐ Yes ☐ No When _____

INFORMED CONSENT

Effective: 01/1/2017

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, discomfort from ice packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

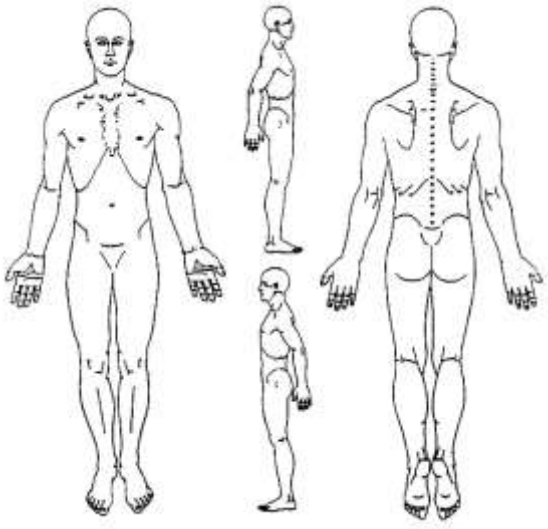
Patient printed name	Patient signature	Patient date of birth	Date
Guardian printed name	Guardian signature	Date	
Witness printed name	Witness signature	Date	

CASE HISTORY

Name: _____ Date of birth: _____ Date: _____

CHIEF COMPLAINT / REGIONS OF PAIN

1. _____
2. _____
3. _____
4. _____



Please mark area of pain on the drawing using the codes listed above

SEVERITY OF PAIN

List region of pain and circle severity number (1 = least, 10 = greatest)

MARK PAIN REGION

Constant • Frequent • Intermittent

i.e. Neck _____ *Constant*

1 2 3 4 5 6 7 (8) 9 10

MARK PAIN AREA

- - - -	Sharp	* * * *	Burning
\ \ \ \	Stabbing	oooo	Dull / Achy
++++	Numbness	xxxxx	Other

REGIONS

Neck _____
1 2 3 4 5 6 7 8 9 10

Mid Back _____
1 2 3 4 5 6 7 8 9 10

Low Back _____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10

PREVIOUS CARE: (Most recent doctors / care providers seen for your chief complaints)

Name	Date seen	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS

☐ Smoking Packs/Day_____
☐ Alcohol Drinks/Day_____
☐ Coffee Cups/Day_____
☐ Soda Cups/Day_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Type_____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother - living ☐ Y ☐ N	☐	☐	☐	☐	☐
Father - living ☐ Y ☐ N	☐	☐	☐	☐	☐
Brother(s), # of_____	☐	☐	☐	☐	☐
Sister(s), # of_____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? If NO, check here: ☐

☐ Alcoholism	☐ Cancer	☐ Epilepsy	☐ Influenza	☐ Mumps	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Goiter	☐ Low Back Pain	☐ Pleurisy	☐ Scoliosis
☐ Appendicitis	☐ Diabetes	☐ Heart Disease	☐ Measles	☐ Pneumonia	☐ Sprain/Strain Sacroiliac
☐ Arthritis	☐ Eczema	☐ HIV Positive	☐ Mental Disorder	☐ Polio	☐ Whiplash

PAST MEDICAL HISTORY

Name: _____ Date of birth: _____ Date: _____

Please enter: "2" (Previously), "3" (Presently), in front of all the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

CONSTITUTIONAL
____ Headache
____ Fever
____ Chills
____ Night Sweats
____ Fainting
____ Dizziness
____ Convulsions
____ Loss of Sleep
____ Fatigue
____ Nervousness
____ Loss of Weight
____ Numbness or Pain in Arms/Legs/Hands
____ Allergies
____ Wheezing
____ Neuralgia

MUSCLES & JOINTS
____ Weakness
____ Twitching
____ Stiff Neck
____ Backache
____ Swollen Joints
____ Tremors
____ Foot Trouble
____ Painful Tail Bone
____ Pain Between Shoulders
____ Spinal Curvature

GASTRO-INTESTINAL
____ Poor Appetite
____ Poor Digestion
____ Starvation
____ Belching or Gas
____ Nausea
____ Vomiting
____ Vomiting Blood
____ Pain over Stomach
____ Constipation
____ Diarrhea
____ Colon Trouble
____ Hemorrhoids (Piles)
____ Fluid Retention
____ Liver Trouble
____ Gout
____ Jaundice
____ Gall Bladder Trouble

CARDIO-VASCULAR
____ Rapid Heart
____ Slow Heart
____ High Blood Pressure
____ Low Blood Pressure
____ Pain Over Heart
____ Heart Trouble
____ Swelling in Ankles
____ Poor Circulation
____ Varicose Veins
____ Strokes
____ Palpitations

EYE/EAR/NOSE/THROAT
____ Poor Vision
____ Crossed Eyes
____ Pain in Eyes
____ Deafness
____ Earache
____ Ear Noises
____ Ear Discharge
____ Nasal Obstruction
____ Nose Bleeds
____ Sore Throat
____ Hoarseness
____ Hay Fever
____ Asthma
____ Frequent Colds
____ Enlarged Thyroid
____ Tonsillitis
____ Sinus Trouble

SKIN OR ALLERGIES
____ Skin Eruptions
____ Itching
____ Bruising Easily
____ Dryness
____ Boils
____ Sensitive Skin
____ Hives or Allergy
____ Eczema

RESPIRATORY
____ Chronic Cough
____ Spitting Blood
____ Spitting Phlegm
____ Chest Pain
____ Difficulty Breathing

GENITO-URINARY
____ Frequent Urination
____ Painful Urination
____ Blood in Urine
____ Kidney Infection
____ Bed Wetting
____ Inability to Control Urine
____ Prostate Trouble

FOR WOMEN ONLY
____ Painful Periods
____ Excessive Flow
____ Irregular Cycle
____ Hot Flashes
____ Cramps or Backaches
____ Vaginal Discharge
Pregnant at this Time ☐ Yes ☐ No
Last Pap_____
By Whom:_____
Other:_____

****All areas left blank I have not/do not have problems with. _____
Initials

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES – HOSPITALIZATIONS

DATE		DATE		DATE		DATE	
_____	Back Operation	_____	Tubes in Ears	_____	Sinus	_____	Hernia
_____	Joint:_____	_____	Appendectomy	_____	Eye	_____	Other:_____
_____	Gall Bladder	_____	Tonsillectomy	_____	Thyroid	_____	Other:_____
_____	Hysterectomy	_____	Stomach	_____	Dental	_____	Other:_____

Hospital Stays _____

List any accidents or falls / with dates: ☐ Car_____ ☐ Recreational Vehicle_____ ☐ Sports_____
☐ School_____ ☐ Other _____

List any broken bone (fractures) or dislocations:_____

Have you ever been on crutches? ☐ Yes ☐ No ☐ Why?_____

Have you ever had a lapse of memory? ☐ Yes ☐ No Have you ever been unconscious? ☐ Yes ☐ No

Have you ever had x-rays taken? ☐ Yes ☐ No ☐ When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting Dr. Betz? _____

Are you presently taking any medication or supplements – prescription or over-the-counter? ☐ Yes ☐ No List: _____

_____

Please list any known allergies? _____ _____

OFFICE FINANCIAL POLICY

PAYMENT / MISSED APPOINTMENTS

We are a cash practice and are considered "out of network" providers. You may pay by Cash, Check, Credit Card, or Care Credit.

You are responsible for your entire bill at the time of service. This office may make payment arrangements on an individual basis. Any such plan or arrangement may be discussed at a pre-scheduled financial appointment.

A charge will be made for broken appointments unless 24 hours' notice is given.

INSURANCE – *PPO, HMO, MAINECARE, etc.*

Because we are considered "out of network" providers, we do not deal directly with insurance carriers. If you have insurance, we will gladly provide an insurance form (hcfa 1500) for you to submit to your insurance company upon your request. Please make sure you tell the receptionist of your need for a form prior to seeing the Doctor.

Maine Care will not pay for visits in our office.

We are not a mediator between you and your insurance company and will not enter into any dispute with your insurance company as your contract is between you and your insurance company. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

MEDICARE

If you have Medicare, a Medicare Alternate or Supplement Plan, please give your card(s) to the receptionist prior to seeing the Doctor.

If you have Medicare and MaineCare or Q.M.B., please give your cards to the receptionist prior to seeing the Doctor.

Although we will submit your claim to Medicare for you, you are responsible for your entire bill at the time of service. Medicare will only reimburse you directly for the services that they cover. If you have further questions, please ask the receptionist.

WORKERS COMP

We accept Worker's Compensation Claims. You are responsible to report this claim to your employer and file the claim. We will handle all billing and collections for the compensable amount as stated by law as payment in full for services rendered. If your claim should go to court and be denied, you are responsible for any remaining balance on your claim.

PERSONAL INJURY / AUTO ACCIDENT

We accept Personal Injury/ Auto Accident claims and will handle all billing and collections through your Med Pay or any other insurance carrier you provide. You are responsible for any outstanding balance remaining, regardless of settlement.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I have read and understand the Office Financial Policy and agree to abide by these terms.

_____	_____	_____	_____
Patient printed name	Patient signature	Patient date of birth	Date
_____	_____	_____	
Guardian printed name	Guardian signature	Date	

CONSENT TO USE PATIENT HEALTH INFORMATION

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Betz Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
-

Notice of Treatment in Open or Common Areas
Private consultation areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____	_____	_____	_____
Patient printed name	Patient signature	Patient date of birth	Date
_____	_____	_____	
Guardian printed name	Guardian signature	Date	
_____	_____	_____	
Witness printed name	Witness signature	Date	

NOTICE OF PRIVACY PRACTICES

Effective: 01/1/2017

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

Betz Chiropractic & Wellness (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE_REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders – We may use and disclose your PHI to remind you by telephone, email or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you, certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief – We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and

certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work, or that we speak with you concerning your PHI in a private area within our office.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Any

use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the practice's **Privacy Officers**. To file a complaint with the United States Secretary of Health and Human Services, you may write to (all complaints must be in writing):

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201.

Privacy Officers – To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the practice's Privacy Officers as follows:

Eric Betz, DC
625 Rockland St., Rockport, ME 04856
207-236-6272

Jocelyn Callahan
625 Rockland St., Rockport, ME 04856
207-236-6272

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. Betz Chiropractic & Wellness reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

By my signature below, I acknowledge receipt of a copy of this Notice of Privacy Practices, my understanding of this notice, and agreement to its terms. I give my permission to use and disclose my health information as stated above.

_____	_____	_____	_____
Patient printed name	Patient signature	Patient date of birth	Date
_____	_____	_____	
Guardian printed name	Guardian signature	Date	
_____	_____	_____	
Witness printed name	Witness signature	Date	