Holmberg Wellness Group

Chiropractic Registration and History

Patient Information

Date _____ SSN _____
Patient Name _____
Address _____
_____
City_____St_____Zip_____
E-Mail _____
Sex [ ] M [ ] F Age _____ Birthdate _____
[ ] Married [ ] Widowed [ ] Single [ ] Child
[ ] Separated [ ] Divorced [ ] Partnered for ___ years
Employer/School _____
Occupation _____
Employer Phone _____
Spouse's Name _____
Spouse's Birthdate _____
Spouse's Employer _____
Names and ages of Children _____
_____
_____
How did you hear about this office? _____

Phone Numbers

Cell # (___)_____ Home # (___)_____

In case of emergency, please contact
Name _____ Relationship _____
Cell # (___)_____ Home # (___)_____

Insurance Information

Who is responsible for this account? _____
Insurance Company _____
ID Number _____
Group Number _____
Insurance Company Phone _____
Is patient covered by additional insurance? [ ] Y [ ] N
Insurance Company _____
ID Number _____
Group Number _____
Insurance Company Phone _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Holmberg Wellnesss Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Medicare Disclaimer

Medicare DOES cover Chiropractic manipulations, with the limitation of manipulations to the spine. Treatment must be determined to be medically necessary. **Medicare does not cover** therapies, supports, nutrition, examinations, x-rays, laboratory studies or maintenance therapy. **Medicare REQUIRES** that a treatment plan be **established and followed**, with the expected results of some functional improvement from sublaxations thus, re-establishing a degree of spinal health. **Medicare will not pay for anything, which it considers to be maintenance** therapy. By my signature I understand and accept this policy, also understanding that I am personally responsible for payment of any procedure, which Medicare determines not, payable under Medicare Part B, and I agree to pay promptly. I further understand that I am liable for my annual deductible and any changes, which are not paid by Medicare or my secondary insurance company.

I understand that it is required for me to have an examination to determine the subluxations, and I understand Medicare does NOT cover this exam and I am responsible to pay for the examination at the time of service.

_____ _____
Signature Date

Accident Information

Is your condition due to an accident? [ ] Yes [ ] No Date of Accident _____
Type of accident [ ] Automobile [ ] Work [ ] Home [ ] Other _____
To whom have you made a report of your accident? [ ] Auto Insurance [ ] Employer [ ] Worker Comp [ ] Other
Attorney name (if applicable) _____
Auto Insurance Company _____ Auto Claim Number _____

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 yes or no to indicate if you have had any of the following:

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

Exercise	Work Activity		Social Habits	
[ ] None	[ ] Sedentary	[ ] Light Labor	[ ] Smoking	Packs/Day
[ ] Moderate	[ ] Sitting	[ ] Heavy Labor	[ ] Alcohol	Drinks/Week
[ ] Daily	[ ] Standing	[ ] Repetitive	[ ] Coffee/Caffeine Drinks	Cups/Day
[ ] Heavy	[ ] Walking	[ ] Computer	[ ] High Stress Level	Reason
			[ ] Recreational Drug Use	

Are you pregnant? [ ] Yes [ ] No Due Date _____

Please provide the following information of your grandparents, parents or siblings (mark with G,P or S)

Have any of the above listed family members had the following?

_____ Allergies / Asthma / Crohns
_____ Mental Illness / Social Dysfunctions
_____ Cerebral Vascular Stroke
_____ Thyroid Disease
_____ Respiratory Disease / Emphysema
_____ Heart Disease / Murmurs
_____ Digestive Diseases / Ulcers / IBS
_____ Arthritis / Scoliosis / Spina Bifida
_____ Liver / Gall Bladder Disease
_____ Diabetes
_____ Kidney / Urinary Tract Dysfunctions
_____ High Blood Pressure
_____ Cancer / AIDS / HIV
_____ Multiple Sclerosis / ALS

njuries/Surgeries you've had	Date
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

Medications	Vitamins/Herbs/ Minerals	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____		

AFFIDAVIT

Patient's statement "Documenting" Medical Necessity of Care, a sworn statement be "Federal" Documentation Format.

PATIENT EXACERBATION DOCUMENTATION AND UPDATE HISTORY QUESTIONAIRE:

Problem 1

Where does it hurt? □ Low Back □ Mid Back □ Neck

□ Other: _____

What date did this start? _____

What were you doing when this episode started?

_____

Please describe it: □ Achy □ Dull □ Diffuse □ Deep

□ Tightness □ Stiffness □ Pulling □ Weakness □ Heavy

□ Sharp □ Shooting □ Burning □ Stinging □ Stabbing

□ Throbbing □ Numbness □ Tingling

□ Occasional □ Intermittent □ Frequent □ Constant

□ Off & On □ Random □ Recurring

How would you rate your pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain Possible

Has this condition been getting:

□ Better □ Worse □ Stayed the same

Which activities do you experience pain when performing?

□ All Movements □ Bending over □ Climbing stairs

□ Dressing □ Driving □ Exercising □ Getting in/ out of car

□ Getting to sleep □ Grocery shopping □ Household chores

□ Lifting Objects □ Looking over shoulder □ Lying down

□ Reaching overhead □ Seated to standing

□ Showering/ bathing □ Sitting □ Standing

□ Staying Asleep □ Using computer □ Walking

□ Yard work □ Other: _____

Does anything relieve or lessen the pain?

□ Nothing □ Chiropractic adjustments □ cold pack

□ Exercise □ Hot pack □ Massage □ Physical Therapy

□ Over-the-counter meds □ Prescription meds □ Rest

□ Stretching □ OTHER_____

Does the pain radiate or travel anywhere?

□ _____

When is this pain the worst?

□ Morning □ During the day □ At Night □ Constant

Is this a result of an accident?

Work: □ Yes □ No Auto: □ Yes □ No

Problem 2

Where does it hurt? □ Low Back □ Mid Back □ Neck

□ Other: _____

What date did this start? _____

What were you doing when this episode started?

_____

Please describe it: □ Achy □ Dull □ Diffuse □ Deep

□ Tightness □ Stiffness □ Pulling □ Weakness □ Heavy

□ Sharp □ Shooting □ Burning □ Stinging □ Stabbing

□ Throbbing □ Numbness □ Tingling

□ Occasional □ Intermittent □ Frequent □ Constant

□ Off & On □ Random □ Recurring

How would you rate your pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain Possible

Has this condition been getting:

□ Better □ Worse □ Stayed the same

Which activities do you experience pain when performing?

□ All Movements □ Bending over □ Climbing stairs

□ Dressing □ Driving □ Exercising □ Getting in/ out of car

□ Getting to sleep □ Grocery shopping □ Household chores

□ Lifting Objects □ Looking over shoulder □ Lying down

□ Reaching overhead □ Seated to standing

□ Showering/ bathing □ Sitting □ Standing

□ Staying Asleep □ Using computer □ Walking

□ Yard work □ Other: _____

Does anything relieve or lessen the pain?

□ Nothing □ Chiropractic adjustments □ cold pack

□ Exercise □ Hot pack □ Massage □ Physical Therapy

□ Over-the-counter meds □ Prescription meds □ Rest

□ Stretching □ OTHER_____

Does the pain radiate or travel anywhere?

□ _____

When is this pain the worst?

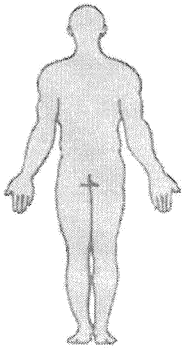
□ Morning □ During the day □ At Night □ Constant

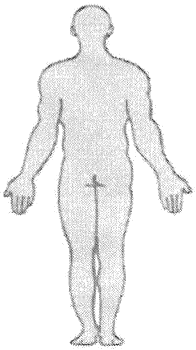
Is this a result of an accident?

Work: □ Yes □ No Auto: □ Yes □ No

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

Problem 1 **Problem 2**





_____

Signature

_____

Printed Name

_____

Date

Functional Rating Index

In order to properly assess your condition, we must understand how much your main problem has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; no restricitons	Mild Pain; no restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe pain; need 100% assistance

Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe pain on short trips

Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activites	Can do a few activities	Cannot do any activities

Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

Lifting

0	1	2	3	4
No Pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after one hour	Increased pain after 1/2 hour	Increased pain with any standing

Printed Name: _____ **Date:** _____

Signed Name: _____

Holmberg Wellness Group

5846 W. 21st St. Suite 100
Wichita, KS 67205
Phone: (316) 945-3200
Fax: (316) 945-1400

Initial Patient Evaluation Disclaimer

I understand that the services for my initial visit with Holmberg Wellness Group will include: a full consultation, examination, x-rays if necessary and the report of findings. No treatment is included with these services. Insurance and out-of-pocket patient responsibility amounts will be covered before any treatment occurs.

_____ _____

Patient Signature Date

Appointment Reminders

If you would like a reminder of your future appointments please select an option below with contact information and phone carrier.

Circle preference: 2 hours before or One day before or Other

- ☐ Email: _____
- ☐ Text: _____ Phone Carrier _____
- ☐ Decline

HOLMBERG
wellness group

Notice of Privacy Practices

Effective November 21, 2013

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.

The Practice (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 obligated to notify you promptly if a breach occurs that may have compromised the privacy and security of 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 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.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

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 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.

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.

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 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 you 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 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 Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

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

Name: Mandy Holmberg

Address: 5846 W. 21st St. N. Ste. 100

Telephone No.: 316-945-3200

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice 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.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

HOLMBERG
wellness group

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Holmberg Wellness Group, LLC.

I understand that the Notice describes the uses and disclosures of my protected health information by Holmberg Wellness Group, LLC and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*