1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Patient Information

Thank you for choosing Springtime Health and Wellness for your chiropractic needs. Please complete this form (front and back). If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name ____________________________________ Date _____/_____/____ Social Security #: ________/_______/________

Address ____ City ____________________ State _____ Zip ____________

Responsible party (if patient is a minor) ____

Address ____

Sex: □F □M Birthdate _____/_____/_____ E-mail ____

Home Phone (_____)__________ Work Phone (_____)__________ ext: _____ Cell Phone (_____)__________

Do you prefer to receive calls at: ○ Home ○ Work □○ Cell □ ○ No Preference

My we contact you at work? ○ Yes ○ No

□ ○ Married □ ○ Widowed □○ Single □○ Minor □○ Separated □○ Divorced □ ○ Partnered

Spouse's or Partner's Name:______________

Child's Name and age: _________________ Child's Name and age:_______________ Child's Name and age: _________

Patient Employer/School ______________________________________ Occupation ___________________________

Employer/School Address ____

Person to contact in case of emergency ____ Phone (_____)__________

How did you hear about us? ____

Have you consulted a chiropractor before: ○ No. ○ Yes. When?_______ What type of adjustment received?__________

Preferred Language: English or other:____________

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Race: ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American

○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Responsible Party/Insurance

Please present the receptionist with your insurance card(s so copies can be made for our records).

Is this visit due to an accident? □ Yes □ No If yes, what type? □ Auto □ Work Comp □ Personal Injury Date _____/_____/_____

Insurance Company ___________________________________ Group # ___________________ ID# ___________________

Subscriber's Name ___________________________________ Birthdate _____/_____/_____ SS# _______________________

Is patient covered by additional insurance? □ Yes □ No If yes, please complete the following information.

Insurance Company ___________________________________ Group # ___________________ ID# ___________________

Subscriber's Name ___________________________________ Birthdate _____/_____/_____ SS# _______________________

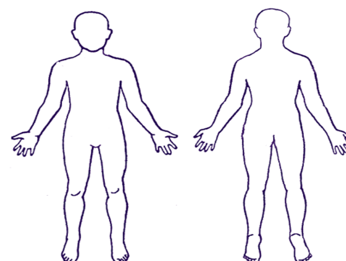
Assignment and Release

I certify that I and/or my dependants have insurance coverage through the above named company and assign directly to Dr. Jamie Lenz 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. Dr. Lenz may use my health care information and may disclose such information to my 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.

____ ______________________

Patient Signature (Parent, if minor) Date

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



Springtime
Health and Wellness

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Patient Health History

Symptom 1 ______________________________________

The Symptom is the result of: ○ An accident or injury? ○ Work ○ Auto ○ Other__○ A worsening long-term problem: ___________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What ***percentage of the time*** you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom ***begin***? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _______________________________________
    - What makes the symptom ***worse***? (circle all that apply):
        - Bending neck forward, bending neck backward, tilling head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting position. lifting, any movement, driving, walking, running, nothing, other (please describe): ____
    - What makes the symptom ***better***? (circle all that apply):
        - Rest. ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
    - Describe the ***quality*** of the symptom (circle all that apply):
        - Sharp, dull, achy, burning, throbbing, piercing. stabbing, deep, nagging, Other (please describe): ____
    - Does the symptom ***radiate*** to another part of your body (circle one): yes no
- Prior Interventions: (What have you done to relieve the symptoms?)____________________
○ Chiropractic ○ Acupuncture ○ Physical Therapy ○ Homeopathic remedies ○ Over the counter drugs
○ Prescription Medication ○ Massage Therapy ○ Ice ○ Heat ○ Other: _______________

Symptom 2 ______________________________________

The Symptom is the result of: ○ An accident or injury? ○ Work ○ Auto ○ Other__○ A worsening long-term problem: ___________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What ***percentage of the time*** you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom ***begin***? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _______________________________________
- What makes the symptom ***worse***? (circle all that apply):
    - Bending neck forward, bending neck backward, tilling head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting position. lifting, any movement, driving, walking, running, nothing, other (please describe): ________
    - What makes the symptom ***better***? (circle all that apply):
        - Rest. ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
    - Describe the ***quality*** of the symptom (circle all that apply):
        - Sharp, dull, achy, burning, throbbing, piercing. stabbing, deep, nagging, Other (please describe): ____
    - Does the symptom ***radiate*** to another part of your body (circle one): yes no
- Prior Interventions: (What have you done to relieve the symptoms?)____________________
○ Chiropractic ○ Acupuncture ○ Physical Therapy ○ Homeopathic remedies ○ Over the counter drugs
○ Prescription Medication ○ Massage Therapy ○ Ice ○ Heat ○ Other: _______________

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
❑Asthma/difficulty breathing ❑ Apnea ❑ Hay fever ❑ Shortness of Breath ❑ COPD ❑ Emphysema
❑ Pneumonia ❑ Other_______ ❑ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
❑ Heart surgeries ❑ Congestive heart failure ❑ Murmurs or valvular disease ❑ Heart attacks/MIs ❑ Heart disease/problems ❑ High blood pressure/Hypertension ❑ Low blood pressure ❑ High cholesterol ❑ Poor circulation ❑ Pacemaker ❑ Angina/chest pain ❑ Irregular heartbeat ❑ Excessive bruising ❑ Other_______
❑ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
❑ Visual changes/loss of vision ❑ One-sided weakness of face or body ❑ History of seizures ❑Pins and Needles
❑ Numbness ❑ One-sided decreased feeling in the face or body ❑ Headaches ❑ Memory loss ❑ Tremors
❑ Vertigo ❑ Loss of sense of smell ❑Strokes/TIAs ❑ Other _____ ❑ None of the above

Have you had any of the following **sensory** issues?
❑ blurred vision ❑ Ringing in the ears ❑ Hearing loss ❑ Chronic ear infection ❑ loss of smell
❑ loss of taste ❑ None of the above

Have you had any of the following **constitutional** issues?
❑ Fainting ❑ Low libido ❑ Poor appetite ❑ Fatigue ❑ Sudden weight gain/ loss ❑ Weakness ❑ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
❑ Thyroid disease ❑ Hormone replacement therapy ❑ Injectable steroid replacements ❑ Diabetes
❑ Immune disorders ❑ Hypoglycemia ❑ Frequent infection ❑ Swollen glands ❑ low energy ❑ Other
❑ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
❑ Renal calculi/kidney stones ❑ Hematuria (blood in the urine) ❑ Incontinence (can't control) ❑ Bed wetting
❑ Bladder Infections ❑ Difficulty urinating ❑ Kidney disease ❑ Dialysis ❑ Other ❑ None of the above
Men: ❑ Prostate Infections ❑ Erectile dysfunction ❑ None of the above
Women: ❑ PMS symptoms ❑ Infertility ❑ None of the above

Have you had any of the following **gastroenterological (stomach-related) issues**?
❑ Nausea ❑ Difficulty swallowing ❑ Ulcerative disease ❑ Frequent abdominal pain ❑ Hiatal hernia
❑ Constipation ❑ Diarrhea ❑Pancreatic disease ❑ Irritable bowel/colitis
❑ Hepatitis or liver disease ❑ Anorexia/ Bulimia ❑ Food Sensitivities
❑ Bloody or black tarry stools ❑Vomiting blood ❑ Bowel incontinence
❑ Gastroesophageal reflux (GERD) ❑ heartburn (acid reflux) ❑ Other_____ ❑ None of the above

Have you had any of the following **hematological (blood-related) issues**?
❑ Anemia ❑ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naproxen/Aleve) ❑ HIV positive
❑ Abnormal bleeding/bruising ❑ Sickle-cell anemia ❑ Enlarged lymph nodes ❑ Hemophilia
❑ Hypercoagulation or deep venous thrombosis/history of blood clots ❑ Anticoagulant therapy ❑ Regular aspirin use o Other
❑ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
❑ Significant burns ❑ Significant rashes ❑ Skin grafts ❑ Psoriatic disorders ❑ Skin Cancer ❑ Eczema ❑ Acne
❑ Hair loss ❑ Other_______ ❑ None of the above

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
❑ Osteoporosis ❑ Arthritis ❑ Scoliosis ❑ Neck Pain ❑ Back problems ❑ Hip disorders ❑ Knee injuries ❑ Foot/ Ankle pain ❑ Shoulder problems ❑ Elbow/ Wrist pain ❑ TMJ issues ❑ Poor posture ❑ Rheumatoid arthritis ❑ Gout ❑ Osteoarthritis ❑ Broken bones ❑ Spinal fracture ❑ Spinal surgery ❑ Joint surgery ❑ Arthritis (unknown type) ❑ Metal implants ❑ Other _________________ ❑ None of the above

Have you had any of the following **psychological issues?**
❑ Anxiety ❑ Depression ❑ Psychiatric diagnosis ❑ Suicidal ideations ❑ Bipolar disorder
❑ Homicidal ideations ❑ Schizophrenia ❑ Psychiatric hospitalizations ❑ Other_____ ❑ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _________________

Past personal, family and social history:

Please identify your past health history including accidents, injuries, illnesses and treatments. Please complete each section fully.

Illnesses

Check the illnesses you **HAD** in the past or **HAVE** now.

Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Aids	○	○	Alcoholism	○	○	Allergies	○	○	Arteriosclerosis
○	○	Cancer	○	○	Chicken Pox	○	○	Diabetes	○	○	Epilepsy
○	○	Glaucoma	○	○	Goiter	○	○	Gout	○	○	Heart Disease
○	○	Hepatitis	○	○	HIV positive	○	○	Malaria	○	○	Measles
○	○	Multiple Sclerosis	○	○	Mumps	○	○	Polio	○	○	Rheumatic fever
○	○	Scarlet fever	○	○	Stroke	○	○	Tubercolosis	○	○	Ulcer
○	○	Other: __________________									

Are you allergic to any medications? ○ No ○ Yes. If yes please list: ____

Injuries: Have you ever…
- ○ Had a fractured or broken bone ○ No ○ Yes. If yes please list: ____
- ○ Had a spine or nerve disorder ○ No ○ Yes. If yes please list: ____
- ○ Been knocked unconscious ○ No ○ Yes. If yes please list: ____
- ○ Been injured in an accident ○ No ○ Yes. If yes please list: ____
- ○ Used a crutch or other support ○ No ○ Yes. If yes please list: ____
- ○ Used neck or back bracing ○ No ○ Yes. If yes please list: ____
- ○ Received a tattoo ○ No ○ Yes. If yes please list: ____
- ○ Had a body piercing ○ No ○ Yes. If yes please list: ____

Operations: Surgical interventions, which may or may not have included hospitalization.
○ Appendix removal ○ Bypass surgery ○ Cancer: _________ ○ Cosmetic Surgery ○ Elective Surgery: ______________
○ Eye Surgery: _______ ○ Hysterectomy ○ Pacemaker ○ Spine: _______○ Tonsillectomy ○ Other: ____________

For Women Only
Are you pregnant? ☐ Yes ☐ No Due Date? _____/_____/_____
Are you nursing? ☐ Yes ☐ No

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Treatments: Check the ones you have received in the **Past** or are **Currently.**

Past	Currently		Past	Currently		Past	Currently	
○	○	Acupuncture	○	○	Antibiotics	○	○	Birth Control Pills
○	○	Blood transfusions	○	○	Chemotherapy	○	○	Chiropractic Care
○	○	Dialysis	○	○	Herbs	○	○	Homeopathy
○	○	Hormone Replacement	○	○	Inhaler	○	○	Massage therapy
○	○	Physical Therapy						
○	○	Medications (Please list all prescription, over-the-counter, natural supplements, enzymes, vitamins, and minerals.)						

Family History:

	Age	State of health		Illnesses	Age at death	Cause of death	
		Good	**Poor**			Natural	Illness
Mother:	______	○	○	___________________________	_____________	○	○
Father:	_______	○	○	___________________________	_____________	○	○
Sister 1 :	_______	○	○	___________________________	_____________	○	○
Sister 2:	_______	○	○	___________________________	_____________	○	○
Brother 1:	_______	○	○	___________________________	_____________	○	○
Brother 2:	_______	○	○	___________________________	_____________	○	○

Are there any other hereditary health issues that you know about? ____

Social History:

Alcohol use: ○ Daily ○ Weekly How much? _____

Tobacco use: ○ Daily ○Weekly How much? _____

Water intake:○ Daily ○ Weekly How much? _____

Pain relievers:○ Daily ○ Weekly How much? _____

Coffee Use: ○ Daily ○ Weekly How much? _____

Soft Drinks: ○ Daily ○ Weekly How much? _____

Prayer or Meditation? ○ Yes ○ No

Job pressure/ stress? ○ Yes ○ No

Financial Peace? ○ Yes ○ No

Vaccinated? ○ Yes ○ No

Mercury fillings? ○ Yes ○ No

Recreational Drugs? ○ Yes ○ No

Exercising/ Physical Activity: ○ Daily ○ Weekly How much? _____ What Type?_______________

Hobbies: ____

Typical Breakfast:_________________________

Typical Lunch: ___________________________

Typical Dinner: ___________________________

Typical Snacks:____________________________

How many meals do you eat out?______________

Print Patient Name: ____

Patient's Signature:____________________________________ Date: _______________

If minor:

Parent's/Guardian Name: ____

Signature____ Date: _______________

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

CONSENT TO TREAT

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic treatment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the journal of the American Medical Association found that more than 2 million Americans become seriously ill each year from reactions to currently prescribed drugs. 106,000 of those people die from the side effects.

I understand the remote possibility of an injury to myself from a chiropractic treatment and elect to receive the recommended treatment.

Print Patient Name: ____
Patient's Signature:____ Date: _______________

Minor Consent to Treat: (Parent or guardian, if minor)

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _______________ As the examining / treating doctor deems necessary. I understand the remote possibility of an injury to my child from a chiropractic treatment and elect him/her to receive the recommended treatment.

Parent's/Guardian Name: ____
Signature____ Date: _______________

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

PAYMENT POLICY

If your insurance policy provides for health services, this is our payment plan.

LIMITED ASSIGNMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month.
Copays are due at time of service or a $10.00 surcharge will be added.

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) If you require an appointment after hours, there is a $50.00 emergency charge that is not covered by your insurance company. Payment is expected at the time of service.

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Springtime Health and Wellness. It is therefore important that **you** contact your insurance company to know your specific medical/ health benefits.

Any charges not paid are considered delinquent. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of $27.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of $20.00 for the missed appointment.
Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

Print Patient Name: ____
Patient's Signature:________________________________ Date: ___________
If minor:
Parent's/Guardian Name: ____
Signature____ Date: ______________

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

NOTICE OF PRIVACY PRACTICES (HIPPA)

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.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Staff member may have to disclose your health information including all of your clinical records to another health care provider or facility if it is necessary to refer you to them for diagnosis, assessment, or treatment of your heath condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Staff member may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Staff member may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
10) We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Wisconsin's workers compensation laws.

Other than the circumstances described in the preceding examples, any other use of disclosure of your health information will only be made with your written authorization.

Marketing

Staff member may need to use your health information including your name, address, phone number and your clinical records for the purpose of marketing products and service to you. We are specifically requesting authorization to market the following products and/or services to you:

We may contact you by phone, mail, e-mail, fax, or other forms of electronic communication:

1) for appointment reminders and/or recall activities
2) with coupons for discounted services and/or products
3) announcing events, classes, or new products/services at our office

We may display inside our office:

1) pictures, cards, letters, drawings, artwork, recipes, jokes, testimonials, and/or things given to us by our patients or their families
2) acknowledgement of new patients, birthdays, anniversary's, and/or thank you for referrals.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or status of your account. We will do our best to accommodate any reasonable request if you would like receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Your request to inspect and/or copy your health information must be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1) Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2) Those disclosures made to you.
3) Those disclosures we are permitted to make without your consent or authorization as described above.
4) Those disclosures made based on an authorization you signed.
5) Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6) Those disclosures for national security or intelligence purposes.
7) Those disclosures made to correctional officers or law enforcement officers.
8) Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw of modify your request.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice. If we make a change to the terms of our privacy agreement we will notify you in writing when you when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will take any action against you if you do so. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact: Dr. Lenz

1001 S Whitney Way Madison WI 53711 Ph: (608) 274-6200 Fax: (608) 278-4586

This notice is effective as of 01/04/2019. This notice will expire seven years after the date upon which the record was created.

____________________________ ________________________
Patient Name (Printed) Date

____________________________ ________________________
Patient (or Representative) Signature Authorized Provider Signature

____
Description of personal representative’s authority to act for the patient