Today's Date: _____

Application for Care at Tabrizi Family Chiropractic

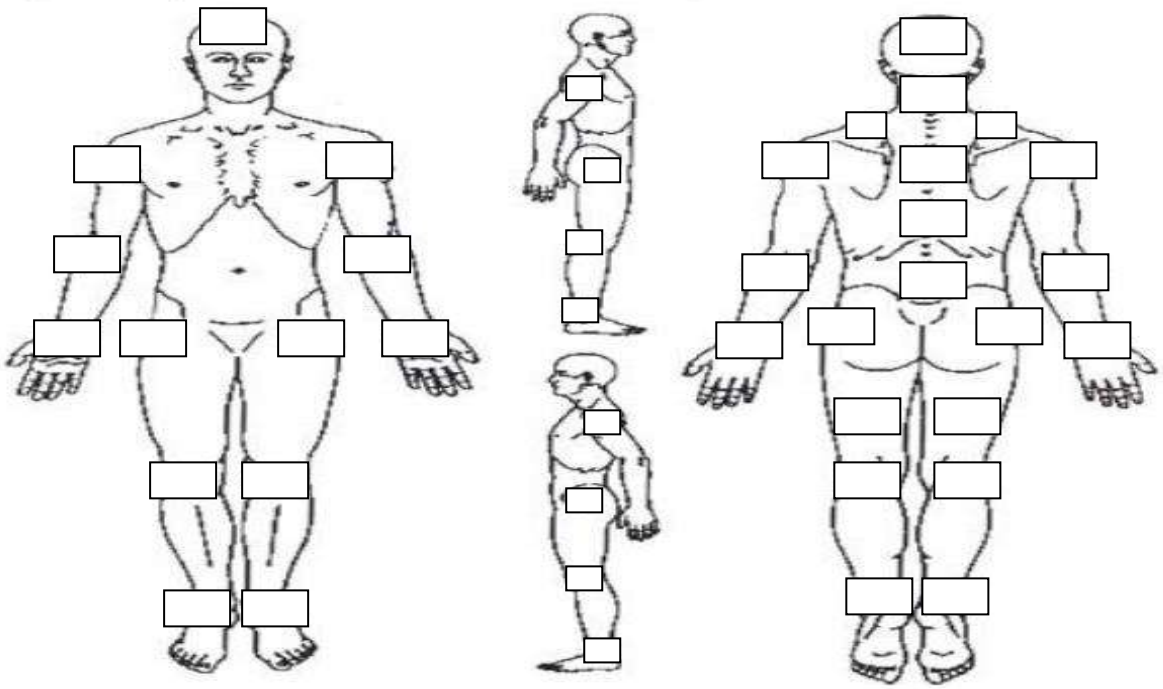
PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐Male ☐Female
Address: _____ City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Marital Status: ❑Single ❑Married ❑Divorced Work Phone: _____
Social Security #: _____
Employer: _____ Occupation: _____
Spouse's Name: _____Spouse's Employer: _____
Name & Number of Emergency Contact: _____Relationship: _____
Do you have Health Insurance: Yes No Company? _____
Insurance ID: _____ ***Plan:*** _____ ***PPO/HMO***
Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT

1) Please identify the condition(s) that brought you in today
Primarily: _____
Secondarily: _____
Third: _____
Fourth: _____

2) PLEASE MARK the areas on the Diagram with the LENGTH OF TIME you have been feeling discomfort/pain in that area (specify number of days/weeks/months/years)



3) How did the injury happen? (be as specific as possible)
_____

4) Is the problem: Radiating Burning Dull Aching Numbness Sharp/Stabbing Tingling Stiff Tight
_____

5) Is the problem: Constant Comes and Goes
_____

6) What makes your symptoms better?
_____

7) What makes your symptoms worse?
_____

8) Is your problem the result of ANY type of auto-accident? Yes No
9) Has this condition(s) ever been treated by anyone in the past? No Yes
If yes, when: _____ by whom? _____
How long were you under care: _____ What were the results? _____
10) Name of Previous Chiropractor: _____N/A

Patient's Name: _____ Patient Signature: _____ Date: ___/___/___

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

Please mark any other symptoms you have experienced marking the following:

P for in the ***Past,*** **C** for ***Currently have*** and **N** for ***Never have had***

___ Headache	___ Numb/Tingling arm, hand	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Pregnant (Now)	___ Loss of Balance	___ Impotence/Sexual Dysfunction	___ Heartburn
___ Right Shoulder Pain	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Left Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Scoliosis	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Right Hip Pain	___ Foot Pain	___ Depression	___ PMS	___ Lung Problems
___ Left Hip Pain	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Left Knee Pain	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Right Knee Pain		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List any other medical/psychiatric conditions that have been previously diagnosed:

_____

_____

_____

List any previous surgeries or other major medical procedures you have had:

_____

_____

_____

List Prescription & Non-Prescription drugs you take & How long you have been taking them:

_____

_____

_____

_____

_____

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

Activities of Daily Living

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

PAST HISTORY

Have you suffered with any of your current complaints or a similar problem in the past? ❑No ❑Yes **If yes** how many times? _____
When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ❑No ❑Yes **If yes,** please state **what type of treatment**: _____,
and who provided it: _____ **How long ago? _____What** were the results. ❑Favorable ❑Unfavorable
please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past,*** **C** for ***Currently have*** and **N** for ***Never have had:***

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture(where?) ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___Osteoporosis

Other serious conditions:
_____

SOCIAL HISTORY

1. **Smoking:** ❑Cigars ❒Pipe ❑Cigarettes → How often? ❑Daily ❑Weekends ❑Occasionally ❑Never
2. **Alcoholic Beverage:** consumption occurs → ❑Daily ❑Weekends ❑Occasionally ❑Never
3. **Recreational Drug use:** → ❑Daily ❑Weekends ❑Occasionally ❑Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

IDENTIFY TYPE:	**EFFECT:**			
_____	❑No Effect	❑Painful (can do)	❑Painful (limits)	❑Unable to Perform
_____	❑No Effect	❑Painful (can do)	❑Painful (limits)	❑Unable to Perform
_____	❑No Effect	❑Painful (can do)	❑Painful (limits)	❑Unable to Perform
_____	❑No Effect	❑Painful (can do)	❑Painful (limits)	❑Unable to Perform

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑grandmother ❑grandfather ❑mother ❑father ❑sisters ❑brothers ❑son(s) ❑daughter(s)
Have they ever been treated for their condition? ❑No ❑Yes ❑I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑No ❑Yes: _____

I hereby authorize payment to be made directly to Tabrizi Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Tabrizi Family Chiropractic for any and all services I receive at this office.

Patient's Name: _____ Patient Signature: _____ Date: ___/___/___

_____
Doctor's Signature

_____ - _____ - _____
Date Form Reviewed

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING

Our office provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result, patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. For quality assurance there are live video recordings in open and public areas. Your signature below indicates your authorization for this activity. In addition, your signature below authorizes us to contact you at all the phone numbers/address you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ **RELIEF CARE:** Symptomatic relief of pain or discomfort of acute/new injuries
- ❑ **CORRECTIVE CARE**: Relief care plus correction of chronic dysfunctions and degenerative changes.
- ❑ **LIFESTYLE CARE:** I would like to have Chiropractic treatment as part of my lifestyle to keep me functioning at my highest capacity.

Office Policy and What You Should Expect On Your First Two Visits

Our office policy is designed to ensure that every patient in our office is treated with the highest level of service.

The First Visit:

Your first visit at Tabrizi Chiropractic is known as **Discovery**. This visit is designed to perform a thorough examination that reveals the underlying conditions that may be causing you symptoms. These tests may be medically necessary to ensure a proper diagnosis. The treating doctor reserves the right to refuse treatment if the patient refuses any of the following tests. Testing that may be performed includes the following:

- Complete history
- Family history
- Chiropractic, orthopedic, neurological testing
- X-ray examination

Insurance/Treatment Fees:

Insurance reimbursement is not guaranteed by your insurance company. It is your responsibility to verify coverage of services with your insurance company**.** Although we accept most insurance and perform a complementary in office benefit analysis, if your insurance company refuses payment, it is your responsibility to properly compensate Tabrizi Family Chiropractic for your co-pay, co-insurance, deductible, or charges not covered by insurance for services rendered.

Second Visit:

It is our policy to review X-ray findings and process X-ray film thoroughly before beginning any kind of treatment. X-ray processing is usually done overnight and can take up to 24 hours. Once your X-rays have been processed and reviewed, the doctor will prepare your second visit, the Report of Findings, which is a consultation designed to thoroughly discuss your X-ray and exam findings, provide proper recommendations, and answer any questions you might have.

Treatment is never performed on the first visit without proper review of X-Ray findings unless otherwise indicated by the doctor.

Fee is due at the time of service unless insurance verification has been provided and discussed with the doctor. Please allow 24 hours for insurance verification in office.

Appointments:

- There is no fee for changing your chiropractic appointment time with an advance phone call (minimum 2 hours' notice).
- **There is a $25 cancellation fee for all missed massage appointments**. There is no fee for cancelled massage appointments with a 24 hour notice.
- If you need to make accommodations for an appointment that exceeds the typical office visit, please do so in advance.

Please be respectful of other patient's time and privacy in our office. We look forward to being a part of your transformation! Welcome to Tabrizi Family Chiropractic!

Patient's Name: _____ Patient Signature: _____ Date: ___/___/___

Informed Consent to Treat

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles which is just a sound of gas releasing between the joint.

Analysis/ examination/ treatment:

As a part of analysis, examination and treatment, you are consenting to the following procedures: **Please Circle All**

Spinal Manipulative Therapy	**Orthopedic Testing**	**Basic Neurological Test**
Range of Motion Testing	**Postural Analysis**	**Traction Therapy**
Muscle Strength Testing	**Radiographic Studies**	**Electrical Stimulation Therapy**
Palpation	**Hot/Cold Therapy**	
Manual Physiotherapy	**Vital Signs**	

Other (please explain): _____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The probability of these complications occurring is extremely rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone, such as osteoporosis or infection, which are checked for during the taking of your history and during examination and x-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are generally described as rare. It is important that you are thorough on describing any previous conditions or underlying conditions that you may be suffering from.

Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. If chiropractic care is not indicated, Dr. Tabrizi is in partnership with OC Alliance Surgery Center and other medical professionals and will make a proper referral. The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment, making it more difficult, and less effective the longer it is postponed. The ultimate goal is not only symptomatic relief, but correction of any underlying musculoskeletal conditions.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patient's Name: _____ Patient Signature: _____ Date: ___/___/___

AUTO ACCIDENT PATIENTS ONLY:

INJURY INFORMATION

Date of Accident: _____

Please write a brief description of how your injury occurred:

_____

_____

Were you the (Driver / Passenger)
Were you stopped? (Yes / No) ……If no, approximate speed: _____mph
Was the other vehicle stopped? (Yes / No)……If no, approximate speed: _____mph
At impact, was your body straight in your seat? (Yes / No) If no, turned to the (Left / Right)
At impact, were you looking straight ahead? (Yes / No) If no, was your head turned to the (Left/Right Up/Down)
Were you aware that you were about to be hit? (Yes / No)
Were you wearing a seatbelt at the time of the accident? (Yes / No)
Did your (chest / head) hit the steering wheel? (Yes / No) Did an airbag deploy? (Yes / No)
Did your head hit the (Windshield / Side Window)? (Yes / No) Did your shoulder hit the door? (Yes / No) Did your knees hit the dashboard? (Yes / No)
Do you have any (cuts /bruises) from the accident? (Yes / No) If yes, where? _____
Did you lose consciousness? (Yes / No) If yes, how long _____

AUTO INSURANCE

Insurance company name: _____

Claim number: _____

Name of claim adjuster: _____

Phone number: _____

Is the other party insured? (Yes / No) If yes, name of auto insurance: _____

TREATMENT INFORMATION

Did you go to the Emergency Room? (Yes / No) If yes, when?

_____

Name of the Hospital Emergency Room:

_____

List any medications that you were given:

_____

List any instructions that you were given:

_____

From the following list, circle the treatment(s) that you received at the Emergency Room:
Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions

List all the doctors that you have seen as a result of your injuries (other than at the ER):

Date Doctor Treatment

- _____
- _____

Do you have any future appointments with any doctor regarding your injuries? (Yes / No) If yes, when and with whom?

_____

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

POWER OF ATTORNEY TO ENDORSE CHECKS

Known All Men By These Present: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the **Tabrizi Family Chiropractic** and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney in Fact for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said **Tabrizi Family Chiropractic** which checks, drafts or money orders are to pay for chiropractic services or the like which have been made by **Tabrizi Family Chiropractic** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said **Tabrizi Family Chiropractic** the full power and authority to do and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the **Tabrizi Family Chiropractic** as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

In Witness Whereof: The undersigned have hereunto set their hands, this

PATIENT SIGNATURE (or Parent/Guardian) DATE

AUTHORIZATION AND ASSIGNMENT

Tabrizi Family Chiropractic, in consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release my information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred.
- I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
- In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of California.
- I further agree that this Authorization and Assignment is irrevocable until all monies owed Tabrizi Family Chiropractic, are paid in full.

PATIENT SIGNATURE (or Parent/Guardian) DATE

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best **and** fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.

• Health/Automobile Insurance

- o Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
- o We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement.
- o If your policy has a deductible feature, it is due at the time of service.

o We will do our very best to answer any questions you may have in regard to your insurance.

• There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

_____

PATIENT SIGNATURE (or Parent/Guardian) DATE:

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at, Tabrizi Family Chiropractic and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- That there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to Tabrizi Family Chiropractic or make other provisions for the protection of the interest
  of; Tabrizi Family Chiropractic **or**
- If a liability claim exists, and my attorney refuses to agree to protect the interest of, Tabrizi Family Chiropractic or in have not engaged the services of an attorney; then payment for services rendered by Tabrizi Family Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

_____

PATIENT SIGNATURE (or Parent/Guardian) DATE

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting Dr. Shervin Tabrizi, D.C.

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, provide assistance with your diagnosis or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whoever answers or on your answering machine.
- We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy rights have been violated.

Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read, understand and agree to NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE (or Parent/Guardian) _____DATE_____