

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- Was anyone else in the vehicle with you? No Yes - (Number of people) _____
- You were? Front seat – Driver / Passenger Rear Seat – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- Name of Driver, if not self: _____ Name of Driver of other vehicle: _____
- Did airbags deploy? No Yes Did Police arrive? No Yes Using Seatbelt? No Yes
- Did you strike the windshield or object in car? No Yes - (Describe) _____
- Were you knocked unconscious? No Yes (How long?) _____
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Your Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____
- Other's Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ Occupation: _____ Claim #: _____
Address: _____ City: _____ State: _____ Zip: _____
Contact Person: _____ Phone: _____ Email: _____

GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: ____ / ____ / ____ Time: ____: ____ AM / PM

Please describe the accident in as much detail as possible? _____

Before the accident/injury:

- Have you ever had any complaints in the involved area before? No Yes
 - If yes - Were they present at the time of the accident/injury? No Yes
 - If yes - Summarize these complaints prior to the accident: _____
- Were you capable of performing all of your work activities without restriction? No Yes

At the time of the accident/injury:

- Did you feel pain immediately after the accident? No Yes Later that day Next day When? _____
- Were you taken anywhere after the accident? No Yes Later that day Next day When? _____
 - If yes, How? _____ Where? _____
 - If yes, Did you receive treatment? No Yes - (Describe) _____

Since the accident/injury:

- Are your symptoms: Improving? Getting Worse? The Same?
- Are your work activities restricted as a result of this accident/injury? No Yes - (How?) _____
- Have you missed any work since this accident? No Yes - (Dates?) _____
- Have you retained an Attorney? No Yes - Name: _____ Phone: _____
 - Address: _____ City: _____ State: _____ Zip: _____

Patient No: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Married / Other / Single
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student Employed Employer: _____
*Referred By: _____

Ethnicity: Hispanic or Latino / Other Preferred Language: _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Primary Care Physician: _____
Home: _____ Mobile: _____ Doctor's Phone: _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Full Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT CASE HISTORY

Name: _____

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/____/____ Describe how this began: _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ Where? _____

• Had any previous Surgery or Interventions in this area? (Describe) _____

• Taken any Medications? OTC / Prescriptions _____

• Had any diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

Describe any Secondary Complaints: _____

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: *NONE* (List) _____

Current Medications: *NONE*

(Already have a list? We can make a copy.) _____

Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Past Health History: (Please list any past...)

Surgeries - Date, Type, and Reason: *NONE*

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Major Injuries/Traumas: *NONE*

Habits:

Cigarettes - (#/day) _____

Alcohol - (amount/day) _____

Coffee/Tea - (cups/day) _____

Rec. Drugs (List) _____

Patient No: _____

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Blank lines for recording pregnancy outcomes and dates.

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

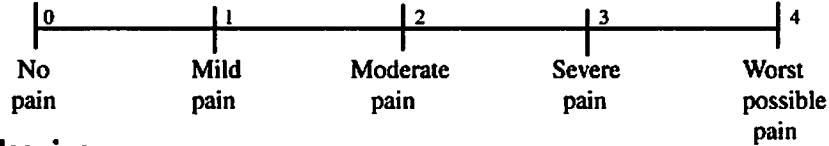
Patient No:

Functional Rating Index

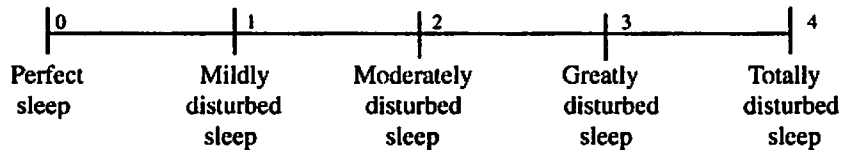
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

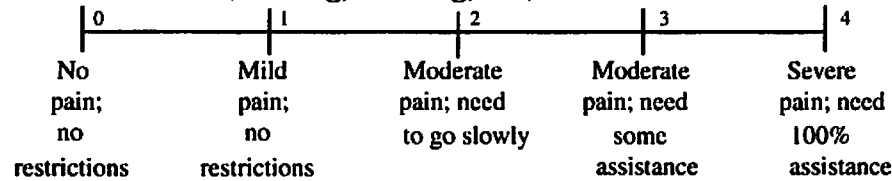
1. Pain Intensity



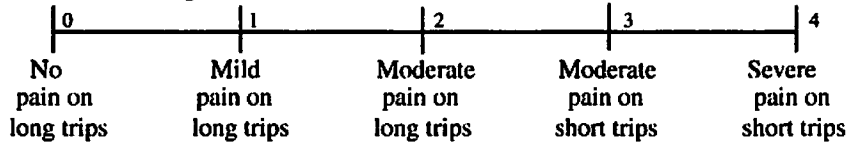
2. Sleeping



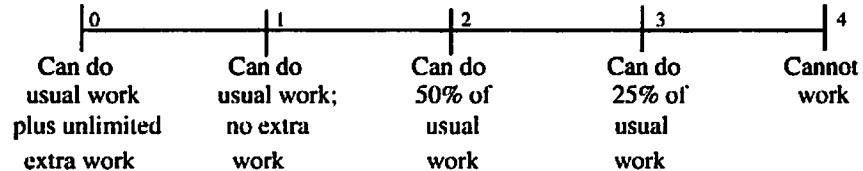
3. Personal Care (washing, dressing, etc.)



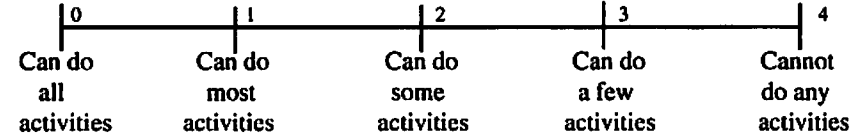
4. Travel (driving, etc.)



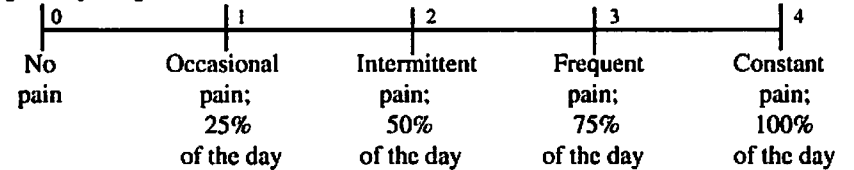
5. Work



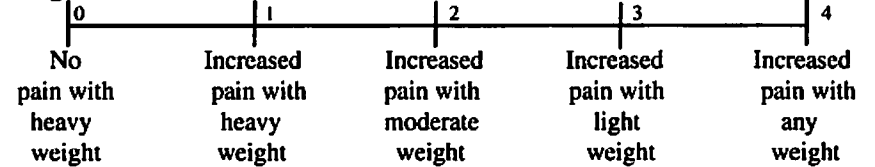
6. Recreation



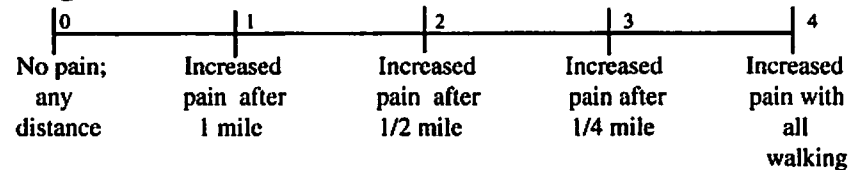
7. Frequency of pain



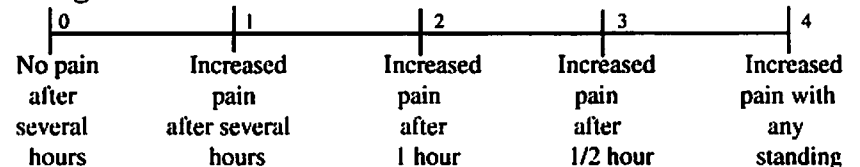
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

Bowker Clinic of Chiropractic and Sports Medicine, LLC
Pinnacle C.O.P. Manual-1.0
Revised 10.20.2014

Patient Name: _____ D.O.B.: _____ Date: _____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Print Name: _____

Patient Signature: _____

Parent / Guardian Signature: _____

Doctor Signature: _____

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Bowker Clinic of Chiropractic to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Bowker Clinic of Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Bowker Clinic of Chiropractic, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Bowker Clinic of Chiropractic for its services rendered.

I appoint Bowker Clinic of Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Bowker Clinic of Chiropractic.

I authorize Bowker Clinic of Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Bowker Clinic of Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Bowker Clinic of Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Bowker Clinic of Chiropractic for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient

Date

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Bowker Clinic of Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Bowker Clinic of Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Bowker Clinic of Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Bowker Clinic of Chiropractic

By: _____ Date: _____

Medpay Information

A lot of people have benefits (MEDPAY) included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage if you have it in the event that you've been injured in an automobile accident, regardless of who is at fault.

Here are three reasons why we recommend that we file your Medpay.

1. **Medpay is similar to health insurance** – Using it does not cause your rates to increase. If your rates do increase, it's not because you filed your Medpay, it's most likely because a) it was determined that you were at fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high risk."
2. **Filing your Medpay doesn't relieve the other party from having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing your Medpay will help to insure that you are not stuck with all of the medical bills.
3. **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

For the same reasons, our office also recommends that you file your commercial health insurance. The important thing to remember is that you are not guaranteed to receive full payment from the other driver's liability insurance company. Filing both your Medpay and your health insurance will help us to insure that you are not left to pay the medical bills. If we receive overpayment on your account, we will be happy to refund you the difference.

Name _____

Date _____

Bowker Clinic of Chiropractic & Sports Medicine

Date: _____

Patient's Name: _____

DOB: _____

To: _____

Fax Number: _____

You are hereby authorized and requested to furnish to:

Dr. Daniel S. Bowker
7005 Shannon Willow Rd. Ste.200
Charlotte, NC 28226

Phone: 704-541-6400

Fax: 704-541-4169

Any and all progress notes, xray reports, lab tests in
your possession concerning the undersigned.

Office Policies for Personal Injury Patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1. Copy of police report and/or a copy of the exchange slip.
2. Name of individual and insurance company of party that is liable. Please include policy number and/or claim number.
3. Copy of personal automobile policy
This is to verify medical payments covered by your automobile insurance.
4. Name and telephone number of attorney if one has been retained.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility and will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

Signature _____

Date _____

BOWKER CLINIC OF CHIROPRACTIC
7005 Shannon Willow Rd, Ste 200
Charlotte, NC 28226

704.541.6400

***(Consent to use PHI) Notice of Privacy Practices - Acknowledgement
& Consent***

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 Bowker Clinic of Chiropractic 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. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Clinical Summary Report(CCR):

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Bowker Clinic of Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed for me to review.

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.

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.

I have received a copy of the Notice of Patient Privacy Policy.

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

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

Notice of Patient Privacy Policy

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. If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Taylor Kirby

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

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website [www."Click & Type"](http://www.Click&Type.com), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

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

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.
- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic interns or preceptors that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *disclosures of psychotherapy notes*
- *uses and disclosures of Protected Health Information for marketing purposes;*
- *disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.
- Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*
- Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.
- You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initiated by them. This copy will serve as your receipt.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.
- **You have the right to be notified by our office of any breach of privacy of your Protected Health Information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Clinical Summary Report(CCR):

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Bowker Clinic of Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed for me to review.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Taylor Kirby. You may contact our Privacy Officer, or any staff member, including Dr. Daniel Bowker at the following phone number 704.541.6400 or our website, at www.bowkerchiropractic.com for further information about the complaint process.