All Ways Chiropractic
Dr. Michael Eekhoff, B.A., D.C.
3773 Martin Way E, Suite B-106, Olympia, WA 98506
Ph: (360) 352-8896 - Fax: (360) 705-0633 - www.AllWaysChiro.com

About You

Today's Date:_____

Legal Name:_____

Preferred Name:

Sex: Male ❒ Female ❒

Date of Birth: ____/____/____

Social Security Number (optional):_____

Marital Status: Married ❒ Single ❒ Divorced ❒ Separated ❒ Widow(er) ❒

Preferred Contact # ❒ Home ❒ Cell ❒ Work ❒ Other
Home #_____Cell #_____

Work #_____Other #_____

Mailing Address_____

City_____State_____Zip Code_____

Email _____

****We will not sell your e-mail for patient communication purposes – It is for internal purposes only.**

Referred by:_____

Patient's Occupation: _____ Employer: _____

Emergency Contact_____ Relationship_____

Phone #_____ ❒ Home ❒ Cell ❒ Work

INSURANCE INFORMATION

Primary Insurance

Insured Name:_____Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

Secondary Insurance

Insured Name:_____Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

All Ways Chiropractic

Amanda Dean, LMP

Dr.Michael Eekhoff,DC,CICE

3773 Martin Way E.
Suite B-106
Olympia, WA 98506
Phone:360-352-8896
Fax:360-705-0633

Massage Informed Consent

I, (patient name, please print) _____ have chosen to consult with and hereby give consent for massage therapy to be provided by the All Ways Chiropractic Licensed Massage Therapists.

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing.

I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of pain, light-headedness, increased inflammation, fatigue or tiredness, possible headache and or nausea. Typically, it is rare to experience all of these symptom's at once.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedure that the therapist performs.

I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Authorized All Ways Chiropractic Employee Signature Date

All Ways Chiropractic, PLLC
and Professional Massage

Massage Intake

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

PRESENT COMPLAINTS: (Please Circle)

Headaches	Nervousness	Fear	Loss of Taste
Mental Dullness	Feet / Hands Cold	Mid Back Stiffness	Irritability
Loss of Memory	Depression	Confusion	Tension
Dizziness	Rib Pain	Constipation	Pins & Needles in Arms
Neck Pain	Neck Stiffness	Unbalanced	Left / Right
Fainting	Shortness of Breath	Chest Pain	Pins & Needles in Hands
Upper Back Pain	Upper Back Stiffness	Ears Ringing	Left / Right
Lower Back Pain	Lower Back Stiffness	Mid Back Pain	Pins & Needles in Legs
Neck Restrictions	Eye Strain / Pain	Blurred Vision	Left / Right

Check the following if you have:

Difficulty in:	❒ Standing	❒ Sitting	❒ Bending	❒ Walking
Pain Radiating to the:	❒ Right Arm	❒ Left Arm	❒ Right Leg	❒ Left Leg
Cannot lift:	❒ Light	❒ Moderate	❒ Heavy	❒ Repetitive
Pain Radiating to the:	❒ Neck	❒ Base of Skull	❒ Shoulders	❒ Arms

Other:

Please list Injuries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Please list Operations/Surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

What is your occupation? _____
Are you allergic to anything? _____
Are you taking any medication? _____
Are you pregnant? _____ Due Date: _____
Do you smoke? *(Please circle)* Yes No If yes, how often per week? _____
Consume alcohol? *(Please circle)* Yes No If yes, how often per week? _____
Exercise? *(Please circle)* Yes No If yes, how often per week? _____

Patient Signature: _____ Date Signed: _____

For Office use: MVA / Worker's Compensation / Health Insurance / TOS DOI: _____

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Massage Intake Questionnaire

How would you rate the level of discomfort right now, on a scale of 1 to 10?

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst?

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best?

1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort. **Gradual?** **Sudden?**

_____

_____

_____

When did the discomfort begin?

_____

_____

For the last few hours? _____
Since the last visit? _____
All day? _____
One day ago? _____
Over a year ago? _____

What aggravates the discomfort?

Bending	Gardening	Sex
Bowling	Jumping	Sitting
Carrying	Kneeling	Sleeping
Cleaning	Lifting	Sliding
Climbing	Lying	Sneezing
Cooking	Medication	Standing
Coughing	Playing Golf	Stooping
Crawling	Playing Tennis	Swinging
Cycling	Pulling	Turning
Dressing	Pushing	Twisting
Driving	Reaching	Typing
Eating	Resting	Walking
Exercising	Running	Working

How many minutes will the discomfort remain that way? _____

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What relieves the discomfort?

Bending
Bowling
Carrying
Cleaning
Climbing
Cooking
Coughing
Crawling
Cycling
Dressing
Driving
Eating
Exercising
Gardening
Jumping
Kneeling
Lifting
Lying
Medication
Playing Golf
Playing Tennis
Pulling
Pushing
Reaching
Resting
Running
Sex
Sitting
Sleeping
Sliding
Sneezing
Standing
Stooping
Swinging
Turning
Twisting
Typing
Walking
Working

What percentage would you say that the discomfort improves?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is the quality of the discomfort?

Aching
Anguish
Burning
Continuous
Deep
Depression
Despair
Discomfort
Dull
Frequent
Insidious
Intense
Intermittent
Malaise
Melancholy
Mild
Moderate
Numb
Numbness
Occasional
Pain
Random
Severe
Self Loathing
Sharp
Shooting
Soreness
Severe

When is discomfort at its worst?

Morning Afternoon Evening Just before bed

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Massage Therapy No Show Policy

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy:
We require 24 hours notice in the event that you need to reschedule or cancel your appointment. If you miss or cancel an appointment without notice in the required time frame, it will result in a No Show charge. This charge cannot be billed to your health insurance or personal injury insurance, and is due immediately.

The first No Show is a **$45.00 charge.**
Further No Shows are a **$65.00 charge.**

By signing below, you are acknowledging that you understand this policy, and that you are financially responsible should these charges occur.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

All Ways Chiropractic

Office Policy

Our goal is to provide exceptional service and ensure that all questions are answered so there is no confusion when it comes to your care at our office. Our office policy allows us to convey how our office runs with a good flow of communication and allows us to meet our goals of exceptional service. Please read our Office Policy carefully and if you have any questions please do not hesitate to ask any member of our staff.

1) We bill your insurance plan as a courtesy to you. We also provide the required documentation to go along with that billing. However, we are NOT participating with ALL insurance companies so it is your responsibility to note any coverage differences when we are an out of network provider.
2) We make every attempt to accurately verify your insurance coverage and to accurately estimate any out-of-pocket expenses you may have; however, it is ultimately your responsibility to understand your plan benefits. It is your responsibility to know if a referral or authorization is required, what services are covered or are not covered, and any out-of-pocket expenses you have under your policy benefits.
3) You are ultimately responsible for your care and agree to accept full responsibility for all services rendered whether they are a covered service or a non-covered service.
4) According to your health insurance and your policy benefits you may be responsible for deductible, co-pays and/or co-insurance. Those fees are due to All Ways Chiropractic and will be collected based upon your health insurance policy.
5) Effective 11/02/2020 Durable Medical Equipment (DME) supplies are not billed to health insurance by All Ways Chiropractic. These supplies are to be paid for at the time of service. You have the option of sending a bill to your health insurance company if you choose.
6) If you do not have health insurance, maxed out your Chiropractic benefits or are doing maintenance care we will extend to you our Time of Service (TOS) rates. The TOS fee is to be paid at the TOS, no exceptions. Our fees for service are the same across the board yet we are able to extend a discount on those fees due to the elimination of ALL billing. Our office saves on clerical costs and we extend that savings to you. To be eligible for our TOS rates you must pay for your care at the TOS. We do not send bills. If we are forced to send a bill due to non-payment at the Time of Service for a forgotten wallet, etc. then the reduced rate will be reversed to our actual cost. Payment for TOS adjustments are due prior to receiving your adjustment to avoid any issues.
7) Patient statements are sent monthly and should arrive to you mid-month.
8) We reserve the right to turn over any unpaid balances to a collection agency.
9) A fee of $25.00 will be assessed on any returned checks.
10) We require 24-hour notice when cancelling a massage. If 24-hour notice is not given then a NO SHOW fee will be added to your account in the amount of $45.00 for the first NO SHOW and $65.00 for each time thereafter. Any NO SHOW fees incurred are *your* responsibility, regardless if you are on an injury claim or if we are billing your health insurance. *A NO SHOW fee is NOT covered by any insurance.* After too many times of not giving proper notice, All Ways Chiropractic reserves the right to not pre-schedule any massages and put you on a call-in only list. We reserve this right because each massage is an hour-long appointment and if you cannot make the time scheduled for you then someone else might be able to utilize that time.
11) Anytime you are sent a new health insurance card our office requires a copy of that card if you want us to bill your new health insurance.
12) Sometimes policies change throughout the year which might change your out of pocket expenses. If this happens then you should be notified by your insurance company.

13) Know your benefits. Your insurance policy is your available health insurance benefits. MOST plans limit the number of Chiropractic, massage and physical therapy benefits that are available for your use. Our office does our due diligence to keep track of how many visits you have used, yet it is ultimately your responsibility to know how many times you come in for care, that includes other Chiropractic offices as well. Your insurance company keeps a count of how many times you are seen by ALL providers which means you need to as well. If you use more visits then what is allowed then each visit thereafter will deny and your cost for the visit will be our actual fee, not your reduced fee in the form of a deductible, co-pay or co-insurance. So, knowing how many visits you have used throughout the year is extremely important. Mark a calendar, keep your appointment cards or check your appt confirmation texts as a means of keeping track. Use whatever works best for you.
14) If you are injured due to a car accident, work injury, slip and fall in an establishment or are a pedestrian that got injured and *whether you are* or *whether you are not going to pursue a claim* then please notify the front desk when scheduling your appointment. If you decided to pursue a claim then please provide the Date of Injury (DOI), type of claim ie: MVA or work injury claim, name of the insurance company, claim number, phone number and the name of the adjuster.

When the patients and the Doctor's office work together it benefits *your* health and when the exchange of services occurs then it allows for a smooth process. Let's all work together for the benefits of you and your health!

Patient Name:_____Date:_____

Patient Signature_____ ***Employee Initials***_____

ALL WAYS CHIROPRACTIC, PLLC

PATIENT FINANCIAL AGREEMENT

Please ***print your initials on the line*** next to your method of payment. This helps with billing procedures and proper record keeping.

_____ **TIME OF SERVICE (TOS):** Payment is expected as the services are rendered. We accept cash, checks, Master Card, Visa, American Express, Discover, Care Credit, FSA (Flex Savings Account) cards, and HSA (Health Savings Account) cards.

_____ **HEALTH INSURANCE**: Co-payments and co-insurance payments are due at the time of service. Please provide us with a copy of the front and back of your health insurance card. Any quote of benefits we receive from your insurance company does not guarantee coverage or insurance payment. We are not responsible for any changes made to your insurance policy. It is your responsibility to know your insurance benefits. Your insurance claims will be billed by an in-house biller or an employee. You are ultimately responsible for your account, which could include deductibles, co-pays, co-ins, non-covered services and denied services.

_____ **PERSONAL INJURY**: Please provide us with all the necessary information needed for billing. This will include the name and phone numbers of ALL insurance companies involved. The claim number(s), date of accident, ALL insured party's name (including third party name), and/or the name of your attorney, if represented. We require an attorney for all third party claims and for those insured with USAA. Our office does not bill health insurance for personal injury claims. We reserve the right to file a lien at any time. You are ultimately responsible for your account and all charges incurred with our office.

_____ **LABOR & INDUSTRIES**: You are responsible for filling out the Labor & Industries long claim form or the claim form necessary for self-insured businesses, which can be done at our office. If you are switching care from another physician, we have the required transfer card available. If your claim is not accepted or services are not covered, you are ultimately responsible for your account and all charges incurred with our office.

_____ **MEDICARE**: Please provide us with a copy of your Medicare card and supplemental health card, if applicable. You are responsible for your annual deductible that begins each January of the New Year. Medicare does not cover x-rays, examinations or maintenance care. Medicare will only pay for services they determine to be medically necessary. You are ultimately responsible for your account with our office.

-Assignment and Release-

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to All Ways Chiropractic, PLLC, 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 hereby authorize the use of this signature on all insurance submissions.

Treatment provided at All Ways Chiropractic is based upon the condition that is being treated. Therapies provided by Dr. Michael Eekhoff can include 1-2, 3-4 or 5 region chiropractic manipulation, extremity adjustment ie: foot, ankle, shoulder, wrist, elbow, rib etc, self-care home management training as well as mechanical traction. These services are provided on an individual basis depending on what is in the best interest of your body and your healing. Treatment is provided based upon medically necessity and will not be discussed prior to any treatment provided while in the adjusting room. If you have any questions please speak with the Receptionist, Office Manager, Dr. Michael Eekhoff. Other therapies offered at All Ways Chiropractic include laser therapy, decompression therapy, massage therapy, nutrition recommendations and supplements as well as Durable Medical Equipment (DME).

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Doctor Signature Date

_____ _____

Attorney Signature Date

ALL WAYS CHIROPRACTIC, PLLC

Dr. Michael Eekhoff
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Notice of Privacy Practices
Signature Page

This notice describes how All Ways Chiropractic PLLC may use and disclose your medical information, and how you may access this information. Please review this notice carefully. If you have any questions about this notice please contact our privacy officer at 360-352-8896 or email at officemanager@allwayschiro.com.

We are required by law to maintain the privacy of your protected Health Information, to notify you of legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information. This notice summarizes our duties and your rights concerning your information.

This Notice of Privacy Practices describes All Ways Chiropractic PLLC practices and that of any of our affiliates. All employees, staff and other personnel will follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or health care operation purposes as described in this Notice.

Changes to this Notice:
We reserve the right to change the terms of out Notice at any time. Any revisions of the Notice will be effective for all Protected Health Information that we maintain at that time. To receive a copy of the revised Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at the time of your next appointment.

All Ways Chiropractic PLLC is commitment to Protecting Medical Information:
We understand and appreciate the personal nature of any information related to you and your health. All Ways Chiropractic PLLC is committed to protecting your medical information, and are required by law to:

- Ensure the privacy of your identifiable medical information
- Provide you with this notice of our legal duties and privacy practices with respect to your medical information
- Follow the terms of the most current Notice.
- I acknowledge I have received a hard copy of All Ways Chiropractic notice of patient privacy policy. Please initial on the line. _____

I have read and understand the Notice of Privacy Practices from All Ways Chiropractic PLLC.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature AWC Employee Initial

NOTICE OF PRIVACY POLICY:

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your Protected Health Information.

"Protected Health Information" refers to information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related to healthcare services.

1) Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Care Information Based Upon Your Written Consent.

You will be asked by All Ways Chiropractic PLLC to sign a consent form. Once you have consented to use and disclosure of your protected Health Information for treatment, payment and health care operations, by signing the consent form, All Ways Chiropractic PLLC will use or disclose your Protected Health Information as described in this Section. Each category of uses and disclosures will be explained but not every use or disclosure in each category will be listed. However, every permissible use or disclosure will fall under one of the following categories.

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.

Payment: Your Protected Health Information will be used and disclosed, as needed, to obtain payment for your health care services. Other uses and disclosures 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. For example Insurance companies that require us to relate to them the services or treatment you are going to receive or have received in this clinic, so they may determine coverage.

Health Care Operations: We may use or disclose, as needed, your Protected All Ways Chiropractic PLLC operations and business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, conducting or arranging for other business activities and compliance with state law.

For example, we may disclose your Protected Health Information to medical students and massage therapists that see patients within our clinic. In addition we may use a sign in sheet at the front desk where you will be asked to sign your name. We may also call you by name in the waiting room when your treating provider 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 will share your Protected Health Information with third party "business associates" that perform various activities such as billing 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 obtain a written contact 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 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 may also send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:

Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Officer. The revocation will not be effective to the extent All Ways Chiropractic PLLC, has already taken action in the reliance on the authorization.

Other permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use and disclose your Protected Health Information in the following instances. You will be granted 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 in our best professional judgment, All Ways Chiropractic PLLC may determine whether the disclosure is in your best interest. In this case, only the minimum necessary Protected Health Information relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you instruct us otherwise, 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 persons involvement in your health care. If you are unable to agree or object to such a disclosure 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.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happened, All Ways Chiropractic PLLC staff shall attempt to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or any All Ways Chiropractic PLLC staff member is required by law to treat you and has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected Health Information to treat you.

Communications Barriers: We may use and disclose your Protected Health Information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclose under circumstances.

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

We may use or disclose your Protected Health Information in the following situations without your consent or authorization. These situations include, but are not limited to the following:

Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure us required by law. The use or disclosure will be made in compliance with the law and will be limited to the minimum necessary. You will be notified, as required by law, of any such uses or disclosures. We may use or disclose your information to state agencies for registry purposes as appropriate and required under State of Washington law.

Public Health: We may disclose the minimum necessary amount of your Protected Health Information for public activities to a public health authority that is permitted by law to collect or receive the information. These uses and disclosures may include, but are not limited to the following:

- To prevent disease, injury or disability
- To report child abuse or neglect by making a telephone report to the appropriate authorities, and to follow this report with a written confirmation.
- To report reaction to medication of problems with products required by the Food and Drug Administration
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a client has been the victim of domestic violence. We will only make this disclosure if you agree, and when consistent, with the requirements or authorizations of applicable Washington State and Federal Law.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual. Any such disclosures would be limited to the minimum necessary, and would be made to someone included in the prevention of the threat.

Military Activity: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel 1) for activities deemed necessary by appropriate military command authorities 2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or 3) to foreign military authority if you are a member of that foreign military services.

Worker's Compensation: We may disclose your Protected Health Information for workers compensation and other similar legally establishes programs, in accordance with state and federal law regarding such disclosures.

National Security: We may disclose your Protected Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Uses and Disclosures: By law, we must make minimum necessary disclosures when required to do so by state, federal, or local law.

2. Your Rights Regarding your Protected Health Information

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.

Right to Inspect and Copy: 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 physician and the practice uses for making decisions about you.
Depending on the circumstances, a decision to deny access may be reviewable. 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. To inspect and/or copy your medical information maintained by All Ways Chiropractic PLLC, you must submit your request in writing to the front desk. You may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with your request.

Right to Request an Amendment: If you feel any of your medical information maintained by All Ways Chiropractic PLLC is incorrect or inaccurate; you may request an amendment of that information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. To request an amendment, your request must be made in writing and must include the reason for the request. All requests for amendment are to be submitted to the front desk.
All Ways Chiropractic PLLC reserves the right to deny your request for amendment for any of the following reasons:

- The information is complete and accurate;
- We did not create the information;
- The person or entity that created the information is no longer available to make the amendment;
- The information is not part of the medical information kept by our facility; or
- The request pertains to information that you are not permitted to inspect and copy.

You have the right to file a statement of disagreement with us. In turn, 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.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices for a time frame of up to seven (7) years from the date of the request. It excludes routine disclosures, such as any we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.
To request an accounting of disclosures, you must submit a written request to the front desk. Your request must state a time period, which may not exceed Seven years. You will not be charged for the first request for accounting within a twelve-month period; however, you may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with any additional requests for accounting. You will be notified of the costs involved and will have the option to withdraw your request at that time, before any costs are incurred.

Right to Request Restriction: You have a right to request that All Ways Chiropractic PLLC restrict the use or disclosure of any part of your Protected Health Information for the purposes of treatment, payment or health care operations. You may also request that your Protected Health Information be disclosed to family members or friends for notification purposes on an all or nothing basis. You must decide whether to grant disclosure to all family and friends, or to none. You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays in full for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

Right to Request Confidential Communications: You have the right to request to receive confidential communications from All Ways Chiropractic PLLC by alternative means or at an alternative location. For example, you may wish to be contacted only at work or by mail. 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. This request must be made in writing to the front desk and must specify how and where you wish to be contacted.

Right to obtain a copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices upon request. To receive a copy of this Notice, or any future revisions of the Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at the time of your next appointment.

3. Complaints

If you believe your privacy rights have been violated, you may file a complaint with

All Ways Chiropractic PLLC or with the Secretary of Health and Human Services. You may also contact our Privacy Officer for further information about the complaint process. We will not retaliate against you for filing a complaint.