APPLICATION FOR CARE AT ABUNDANT HEALTH PHYSICAL MEDICINE

****Please complete in BLACK ink****

Today's Date: ___________________ CT#: ____________________

PATIENT DEMOGRAPHICS

Name: ____ Birthdate: _____-_____-_____ Age: _______ ○ Male ○ Female

Address: ____ City: ________________________________ State: _____ Zip: ___________

Home Phone: ________________________ Work Phone: _______________________ Mobile Phone: ________________________

E-mail Address: ___________________________________ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Social Security #: __________________________________ Driver's License #: ____

Employer: _______________________________________ Occupation: ____

Spouse's Name _______________________________________ Spouse's Employer ____

Number of children and ages: ____

Name & Number of Emergency Contact: ________________________ ___________________Relationship: _______________________

How did you hear about our practice?: ____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: ____

Secondary: _________________________ Third: ____________________________ Fourth: _________________________________

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ________________________ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

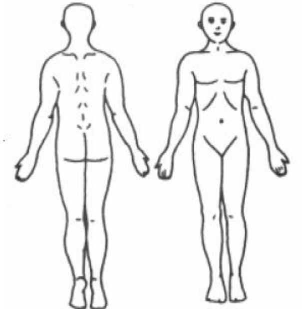
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? ____

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? ____

Name of previous physician: ___________________________________ ☐ **N/A**



PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? ____

What makes your symptoms feel worse? ____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

PATIENT'S NAME: ____ HR#: _____________ DATE: ___________

Is your problem the result of ANY type of accident? ○ Yes ○ No

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

____

____

PAST HISTORY

Have you suffered with any of this 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:

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

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: ________________

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ 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:

____

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? (See Activities of Life form)

Continued on next page/reverse side

PATIENT'S NAME: ____ HR#: _____________ DATE: ___________

I hereby authorize payment to be made directly to Abundant Health Physical Medicine, 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 Abundant Health Physical Medicine for any and all services I receive at this office.

______________________________________ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

______________________________________ _____ - _____ - _____

Provider's Signature **Date Form Reviewed**

PATIENT'S NAME: ____ HR#: _____________ DATE: ___________

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

ACTIVITIES:		**EFFECT:**		
Carry Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sit to Stand	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Climb Stairs	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Pet Care	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Extended Computer Use	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Lift Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Read/Concentrate	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Getting Dressed	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Shaving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sexual Activities	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sleep	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Sitting	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Standing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Yard work	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Walking	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Washing/Bathing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sweeping/Vacuuming	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Dishes	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Laundry	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Garbage	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Driving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Other: _________________	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform

List Prescription & Non-Prescription drugs you take: ____

____

____

____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

____ _____ - _____ - _____

Signature **Date Form Reviewed**

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ 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	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

_______________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

_______________________________________ ______ - ______ - ______

Provider's Signature **Date Form Reviewed**

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

ALLERGY QUESTIONAIRE

CIRCLE ALL THAT APPLY:

Do you suffer from allergies? YES NO

If yes, which seasons: SPRING SUMMER FALL WINTER ALL YEAR

If yes, which of the following symptoms do you typically have:

SNEEZING ITCHY AND/OR WATERY EYES SCRATCHY THROAT CONGESTION CHRONIC COUGH FATIGUE

RESTLESSNESS POST NASAL DRIP JOINT PAIN ITCHY DRY SKIN HIVES RUNNY NOSE

OTHER: ____

How long have you had these symptoms? ___________years ________________months

When do you typically experience them the most: Morning Afternoon Night All Day

YES NO Do you frequently get sinus infections, colds, flu, or a runny nose?

YES NO Have you been diagnosed with Asthma? If yes, is it controlled? YES NO

YES NO Do you take any antihistamine medications to control these symptoms? If yes, please list them below & date last taken: ____

PREFERRED PHARMACY :____

Please list ALL medications you are currently on, and the date last taken:

____

YES NO Are you pregnant? If no, are you planning on becoming pregnant within the next year? YES NO

YES NO Are you HIV positive or have AIDS?

YES NO Are you taking any Beta Blocker Medications? If yes, which one: ________________________

YES NO Are you taking any Antibiotic Medications? If yes, which one: ___________________________________

YES NO Do you have any Auto Immune Diseases? If yes, which one: __________________________________

YES NO Have you been Allergy Tested in the last 12 months? If yes, are you on immunotherapy? YES NO

YES NO Are you planning on relocating within the next 12 months?

YES NO Have you ever had a life threatening allergic reaction and need emergency medical attention?

YES NO Do you have Dermagraphism?

YES NO Do you have any known food allergies? If yes, which one: ____

Patient Signature: ____ Date: ____________________

Allergy Tech Name: _________________________________ Allergy Tech Signature: _________________________________

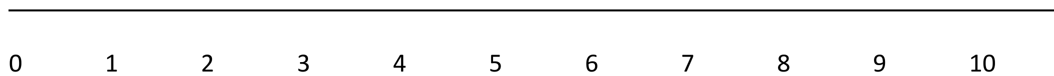
PATIENT'S NAME: ____ HR#: ______________ DATE: ____________

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

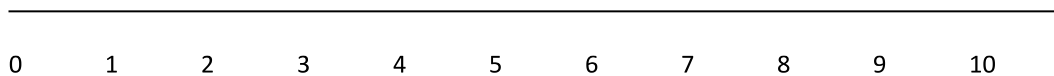
Please **circle** the number that best describes the question asked pertaining to your **primary complaint**. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

1. How would you rate your pain RIGHT NOW?



2. What is your typical or AVERAGE pain?



3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

What percentage of your awake hours is your pain at its best? ______%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

What percentage of your awake hours is your pain at its worst? ______%

Patient Signature: ____ Date: __________________

Score: Q1____+Q2____+Q4____=____ /3x10=____ (Low Intensity = <50; High Intensity = >50)

PATIENT'S NAME: ____ HR#: ______________ DATE: ____________

ABUNDANT HEALTH PHYSICAL MEDICINE

Informed Consent

REGARDING: Medical Services, Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at [Insert Practice Name] have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____________________________________	____________________________________	____/____/____
Patient Name (print)	Patient Signature	Date
____________________________________	____________________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
____________________________________	____________________________________	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____________________________________	____________________________________	____/____/____
Patient Name (print)	Patient Signature	Date
____________________________________	____________________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
____________________________________	____________________________________	____/____/____
Witness Name (print)	Witness Signature	Date

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

Extracorporeal Shockwave Therapy Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy) also known as Softwave Therapy (Tissue Regeneration Technology) and also nicknamed "The Stem Cell Machine" by the TV series "The Doctors."

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Are you on NSAIDS or anti-coagulant treatment? Yes / No
- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer / tumor? Yes / No
- Do you have a tear in the tendon? Yes / No
- Do you have a skin infection? Yes / No
- Are you pregnant? Yes / No

RISKS OF THIS PROCEDURE

a) Pain and soreness. This is temporary and resolves after a week.
b) The FDA has labeled this a Non Significant Risk factor therapy. (NSR)

Consent for Procedure

I, ______________________________, The Undersigned, do herby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of

____

I have been fully informed of focal ESWT which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirmed that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Signed ___________________________________ Date __________________________

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

ABUNDANT HEALTH PHYSICAL MEDICINE

878 Middle Road

Bettendorf, IA 52722

563-275-6332

____

Date

____________________________ ____________________________

Print Name Signature

DO YOU HAVE A PACEMAKER?

☐ Yes

☐ No

*****************************OFFICE USE ONLY**********************************

☐ **OK** to distribute TENS unit

☐ **DO NOT** distribute TENS unit

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

Policy & Procedure

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW TO ACCESS THIS INFORMATION.

Please review it carefully.

WHO WILL FOLLOW THIS NOTICE

THIS NOTICE DESCRIBES THE HEALTH INFORMATION PRIVACY PRACTICE FOLLOWED BY OUR EMPLOYEES, STAFF, AND OTHER CLINIC PERSONNEL. The practice described in this notice will also be followed by the healthcare providers you consult with by telephone who will provide "on call coverage" for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and services you receive at our clinic. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with health treatment or services. We may disclose health information about you to doctors, nurses, technicians, clinic staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your health history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our clinic may share information about you and disclose information to people who do not work in our clinic in scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your health care outside this clinic and may require information about what we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this clinic may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you receieved here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatement.

For Health Care Operations: We may use and disclose health information about you in order to run the clinic and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or health care at the clinic.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternative that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products or services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your *Consent* at any time by giving us a written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time. If you revoke your *consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations and we may therefore choose to discontinue providing you with health care treatment and services.

Special Situations: We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by Federal, State, or Local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the resercher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the clinic.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Workers Compensation: We may release health information about you for the Workers Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deahts, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
Health Oversight Activites: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain State and Federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a subpoena.
Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family & Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we infer from the circumstances, based on our professional judgement that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you to the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or health emergency), we may, using our professional judgement, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgement and experience to make reasonable inference that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, health supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization* in wiritng, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your writing *Authorization*, but we cannot take back any uses or disclosures already made with your permission.
If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Conse*nt mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain aout you:
Right to Inspect and Copy: You have the right to inspect and copy our health information, such as health and billing records, that we use to make decisions about your care. You must submit a written request to the Privacy Officer contact in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. Should such a review be required be mandated by Federal or State law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
Right to Amend: Should you believe that your health information in our records are incorrect or incomplete, you may submit a request to amend the alleged incorrect or incomplete information. Such right to request an amendment is available as long as your health records are maintained by our clinic. To request an amendment, complete and submit a Health Record Amendment/Correction Form to the Privacy Officer contact. We may retain the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a.) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b.) Is not part of the records maintained at our clinic.

c.) You would not be permitted to inspect and copy.
d.) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer contact. It msut state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the *Request For Restriction On Use/Disclosure of Health Information* to the Privacy officer contact.

Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the *Request for Restriction On Use/Disclosure Of Health Information And/Or Confidential Communication* to the Privacy Officer contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to recevie it electronically, you are still entitiled to a paper copy. To obtain such copy, contact Privacy Officer contact.

THIS NOTICE IS SUBJECT TO CHANGE

We reserve the right to change this notice, and to make the revised or changed notice effective for the health information we already have about you as well as any information we receive in the future. We will post summary of the current notice in the clinic with its effective date in the top right hand corner. Your are entitiled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, contact the Privacy Officer contact person for the clinic who is responsible for such complaints and also named on the first page of this notice as the contact for more inofrmation regarding this notice. You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE

Please note that the effective date of this notice shall be August 1, 2020 as mandated by Federal Law and subject to change.

PATIENT'S NAME: ____ HR#: _______________ DATE: _____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: __________________________________ DOB: _____________________

I acknowledge that I have reviewed the Notice of Privacy Practices of Abundant Health Physical Medicine.
(Please INITIAL one of the following options and sign below.)

__________ YES, I wish to receive an electronic copy of Privacy Notice.

__________ NO, I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

If YES, Please fill out your email address below:

My email address is: ____

Please INITIAL below:

__________ I acknowledge that it is the policy of Abundant Health Physical Medicine to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Front Desk about my concerns to be forwarded to the appropriate department.

____ __________________________
Signature of Patient/Guardian **Date**

____ __________________________
Witness (Office Staff) **Date**

PATIENT'S NAME: ____ HR#: ______________ DATE: ____________

HIPAA Personal Health Information Release

I, _______________________________, hereby authorize [Insert Practice Name] to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: ____
- ○ Significant Other Name: ____
- ○ Parent/Legal Guardian Name: ____
- ○ Child(ren) Name(s): ____
- ○ Any Specified Person Name: ____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ○ my home ○ my work ○ my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ ____

I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: ____ Date: ___________________