Welcome

PATIENT INFORMATION

NAME | DATE | SOCIAL SECURITY#

STREET ADDRESS | P.O. BOX (street address also needed)

CITY | ZIP

DO YOU PREFER PHONE CALLS AT: ☐ HOME ☐ WORK ☐ NO PREFERENCE | BEST TIME TO CALL

HOME PHONE | CELL PHONE NUMBER | CELL PHONE PROVIDER

WORK PHONE | EMAIL ADDRESS (Necessary for important notices and newsletters)

AGE | BIRTHDATE | GENDER: ☐ M ☐ F | ☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED ☐ OTHER

PATIENT EMPLOYER/SCHOOL | OCCUPATION

EMPLOYER ADDRESS

CITY | ZIP

SPOUSE OR PARENT NAME | CONTACT PHONE

HOW DID YOU HEAR OF MELBY CHIROPRACTIC? ☐ WEBSITE ☐ MAILER ☐ WORD OF MOUTH ☐ SIGN ☐ PHONE BOOK ☐ OTHER

WHOM MAY WE THANK FOR REFERRING YOU TO US?

RESPONSIBLE PARTY (If other than patient)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT | RELATIONSHIP TO PATIENT

PHONE | ADDRESS

CITY | STATE | ZIP

NAME OF EMPLOYER | WORK PHONE

INSURANCE INFORMATION

NAME OF POLICY HOLDER | RELATIONSHIP TO PATIENT

POLICY HOLDER'S BIRTHDATE | POLICY HOLDER'S SOCIAL SECURITY NUMBER

NAME OF EMPLOYER (if not stated above) | WORK PHONE

EMPLOYER ADDRESS

CITY | STATE | ZIP | **Do you have a Health Savings Account or Health Reimbursement Account? Yes or No**

HEALTH INFORMATION

REASON FOR VISIT ☐ WELLNESS CARE ☐ OTHER (please explain):

DATE OF YOUR LAST PHYSICAL EXAM

WOMEN: ARE YOU PREGNANT? ☐ YES ☐ NO ☐ MAYBE NURSING? ☐ YES ☐ NO BIRTH CONTROL? ☐ YES ☐ NO

LIST ANY ALLERGIES YOU ARE AWARE OF:

Animals Bees Chocolate Dairy Dust Eggs Latex Molds Ragweed/Pollen Rubber Seasonal Allergies Shellfish Soaps Wheat X-ray Dye

Allergy to Medication(s) _____

CONTINUE ON BACK →

LIST ANY SURGERIES YOU HAVE HAD AND DATES:

☐Back ☐Brain ☐Elbow ☐Foot ☐Hip ☐Knee ☐Neck ☐Neurological ☐Shoulder ☐Wrist ☐Other: _____

LIST ANY MEDICATIONS YOU MAY CURRENTLY BE TAKING and WHAT THEY ARE FOR:

MEDICATION/PURPOSE	MEDICATION/PURPOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY

CHECK ALL THOSE WHICH ARE APPLICABLE :

☐AIDS/HIV
☐Alcoholism
☐Allergy Shots
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding Disorders
☐Breast Lump
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependency
☐Chicken Pox
☐Chronic Fatigue
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐Fractures
☐Fibromyalgia
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heart Disease
☐Hepatitis
☐Hernia
☐Herniated Disc
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Kidney Disease
☐Liver Disease
☐Measles
☐Migraine/ Headaches
☐Miscarriage
☐Mononucleosis
☐ Multiple Sclerosis
☐Mumps
☐Osteoporosis
☐Pacemaker
☐Parkinson's
☐Pinched Nerve
☐Pneumonia
☐Polio
☐Prostate Problems
☐Prosthesis
☐Psychiatric Care
☐Rheumatoid Arthritis.
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis

DATE OF YOUR LAST PHYSICAL EXAMINATION	HAVE YOU HAD ANY OTHER ACCIDENTS? ☐ YES ☐ NO

DAILY HABITS

WHAT TYPE OF EXERCISE DO YOU PARTICIPATE IN? (ex: walking, running, aerobics, weight training, yoga, pilates, etc.)

HOW OFTEN DO YOU EXERCISE? ☐ LESS THAN WEEKLY _____ TIMES PER WEEK

WHAT DO YOUR DAILY WORK HABITS INCLUDE? (ex: sitting, standing, light labor, heavy labor, computer work):

DO YOU CURRENTLY SMOKE? ☐ YES ☐ NO HAVE YOU SMOKED IN THE PAST? ☐ YES ☐ NO	SMOKER: HOW MUCH PER DAY?	

HOW MUCH ALCOHOL DO YOU CONSUME ON A WEEKLY BASIS?

HOW MUCH COFFEE OR CAFFEINATED BEVERAGES DO YOU CONSUME ON A DAILY BASIS?

COMPLAINTS / SYMPTOMS

PLEASE USE THE LETTERS IN THE KEY TO INDICATE THE TYPE AND LOCATION OF THE SENSATIONS YOU ARE EXPERIENCING:

KEY:

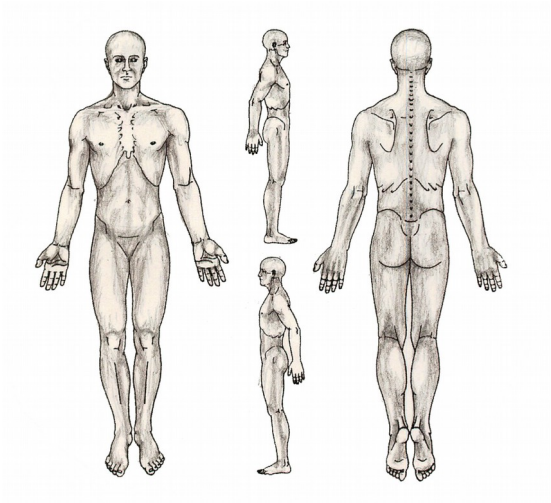
A= ACHE

B= BURNING

N= NUMBNESS

P= PINS & NEEDLES

S= STABBING



□Have you had chiropractic care in the past? YES NO

□ BECOME PAIN FREE
□ EXPLANATION OF MY CONDITION
□ LEARN HOW TO CARE FOR MY CONDITION
□ REDUCE SYMPTOMS
□ RESUME NORMAL ACTIVITY LEVEL

WHAT IS YOUR MAJOR COMPLAINT:	DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: ☐ YES ☐ NO	HOW IS YOUR CONDITION CHANGING: ☐ BETTER ☐ WORSE ☐ SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

☐CONSTANTLY (76-100% of the day) ☐FREQUENTLY (51-75% of the day) ☐OCCASIONALLY (26-50% of the day) ☐INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

☐SHARP ☐DULL ACHE ☐NUMB ☐BURNING ☐ SHOOTING ☐ TINGLING ☐ RADIATING PAIN ☐TIGHTNESS

☐STABBING ☐THROBBING ☐OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= fully unable to perform activities): 0 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION (working, exercise, driving, standing, bending, lifting, etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, pain medication, rest, etc.):

WHAT IS YOUR SECOND COMPLAINT:	DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: ☐ YES ☐ NO	HOW IS YOUR CONDITION CHANGING: ☐ BETTER ☐ WORSE ☐ SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

☐CONSTANTLY (76-100% of the day) ☐FREQUENTLY (51-75% of the day) ☐OCCASIONALLY (26-50% of the day) ☐INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

☐SHARP ☐DULL ACHE ☐NUMB ☐BURNING ☐SHOOTING ☐TINGLING ☐RADIATING PAIN ☐TIGHTNESS

☐STABBING ☐THROBBING ☐OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= no possible activities): 0 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION (working, exercise, driving, standing, bending, lifting etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, pain medication, rest, etc.):

WHAT IS YOUR NEXT COMPLAINT:

DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: ☐ YES ☐ NO

HOW IS YOUR CONDITION CHANGING: ☐ BETTER ☐ WORSE ☐ SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

☐CONSTANTLY (76-100% of the day) ☐ FREQUENTLY (51-75% of the day) ☐ OCCASIONALLY (26-50% of the day) ☐ INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

☐SHARP ☐DULL ACHE ☐NUMB ☐BURNING ☐SHOOTING ☐TINGLING ☐RADIATING PAIN ☐TIGHTNESS

☐STABBING ☐THROBBING ☐OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= no possible activities): 0 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION (working, exercise, driving, standing, bending, lifting, etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, pain medication, rest, etc.):

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I or my minor child have insurance coverage with _____ (name of ins. co.) and assign directly to Melby Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Melby Chiropractic Clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE	DATE
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE	DATE

PATIENT NAME _____
DATE _____

FAMILY HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of the family member, Leave blank those spaces that do not apply. **Circle your answers if your relative lives around this locality**, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHERS Age ( ) Age ( )	SISTERS Age ( ) Age ( )	CHILDREN Age ( ) Age ( )
Back Pain						
Bedwetting						
Disc Problem						
Fibromyalgia						
Headache/Migraine						
Neck Pain						
Numbness						
Pain in Arms/Legs						
Pinched Nerve						
Sciatica						
Shoulder/Arm Pain						
Scoliosis						
Arthritis						
Asthma/Hay Fever						
Bursitis						
Constipation						
Diabetes						
Emphysema						
Epilepsy						
Heart Trouble						
High Blood Pressure						
Insomnia						
Sinus Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

I certify the information provided is accurate to the best of my knowledge:
Name of Patient _____

Signature of Patient/Legal Guardian _____ Date: _____

Notice of Privacy Practices

Effective September 23, 2013

THIS NOTICE DESCRIBES HOW THE CHIROPRACTIC DOCUMENTATION (MEDICAL RECORDS) AND OTHER PERSONAL HEALTH INFORMATION OBTAINED IN THIS OFFICE ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This chiropractic office (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. ***The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.***

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to chiropractic physicians, chiropractic technicians, chiropractic assistants, medical physicians, nurses, medical technicians, clinicians, chiropractic or medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the
referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Health Care Operations – We may use and disclose your PHI for our own health care compliance operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate with all necessary rules and regulations to be compliant and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

There are other uses of PHI where the Practice may also use and or disclose your PHI without your consent or authorization in the following instances:

Personal:

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, wellness visits or exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – Certain limited PHI that is directly related to that person's involvement with your care or payment for your care may be disclose to a family member, other relative, a close friend, or any other person identified by you. We may use or disclose your PHI to notify those persons of your location or general condition or if an emergency situation should occur. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others about your PHI.

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Business Associate:

Business Associate – The Practice contracts with several Business Associates and may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Government Agency related:

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- 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.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

J**udicial and Administrative Proceedings** – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

Disaster Relief - In the event of a disaster occur, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – Where appropriate, the Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes such as testimonials for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you
agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. **You may be charged a fee for the cost of copying, mailing or other expenses related with your request.**

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: William I. Melby, D.C.

Address: 1208 Main Street

Telephone No.: 262-878-4109

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____