Pediatric New Patient Information

Patient Information

Child's Name: ______________________ Child's Nickname:________________ Date:________
Sex: M / F Date of Birth:_____________ Age:________
Address:____
City, State, Zip____
Phone Number:______________ Parent Email:____
In case of an emergency, who should we contact? (Name and contact information):__________
____
Who may we thank for referring you:____

Family Information

Parent Name:_________________________ Parent Name:_________________________
Main Phone:__________________________ Main Phone:__________________________
Work Phone:__________________________ Work Phone:__________________________
Parent's Marital Status: Married____ Single____ Divorced____ Widowed____
List ages of other children in the family:______________________________________

Today's Visit

Reason for today's visit?____
Please circle yes or no and fill in the blank if necessary
Y / N Does your child complain of pain or discomfort? If yes, when did this occur?_________
____
Was the onset sudden or gradual?_____ Is the problem constant or intermittent?______
Y / N Has your child had this problem before?_______________________________________
Y / N Has your child previously been treated for this problem? By whom?_________________
Y / N Has your child previously had a chiropractic care? By whom?_______________________

Mother's Pregnancy History

How many children do you have?_______ What was the term of your pregnancy?______weeks
During your pregnancy, did you have any of the following:
Y / N Falls____
Y / N Motor Vehicle Accidents____
Y / N Near-miss MVA____
Y / N High Blood Pressure____
Y / N Diabetes____
Y / N Anemia____
Y / N Morning Sickness____
Y / N Indigestion____
Y / N Seizures____
Y / N Swollen Ankles____
Y / N Thyroid Problems____
Y / N Heart Problems____
Y / N Back Pain____

Y / N Abnormal Bleeding____
Y / N Were you Hospitalized____
Y / N Any other illnesses____
Y / N Chiropractic care____

During your pregnancy, did you use any of the following:
Y / N Tobacco____
Y / N Alcohol____
Y / N Non-prescribed drugs____
Y / N Prescription medication: Medication____________________Reason_________________
Y / N Over-the-counter meds: Medication____________________Reason_________________
Y / N Vitamins or Supplements____

Birth History
How long was the labor from the first regular contraction to the birth? _____________hours
How long was the 2nd stage (the pushing phase) of the labor? __________min/hours
Y / N Hospital birth____
Y / N Home birth____
Y / N Midwife assisted____
Y / N Vaginal delivery____
Y / N Planned C-section____
Y / N Emergency C-section____
Y / N Was birth induced (Pitocin)_______________________________________
Y / N Forceps delivery____
Y / N Vacuum extraction____
Y / N Anesthesia administered (Epidural)________________________________
Y / N Fetal distress____
Y / N Meconium staining____
Y / N Head presentation____
Y / N Face presentation____
Y / N Breech presentation____

Baby's Condition Immediately After Birth:

APGAR Score:	at 1 minute ___/10	at 5 minutes___/10	
Baby's Crying:	Baby cried immediately after birth____		
	Cried strong___	Weak cry___	Didn't cry for ___minutes
Baby's Color:	Pink all over___	Blue face___	Blue hands/feet____
Baby's Activity:	Arms and legs actively moving___	Floppy baby____	
Intensive Care	Was required_____	Days in Neonatal Intensive Care Unit_____	

Medication given at birth____________________ Vaccines administered___________________
Was Baby Jaundiced?________Supported with a bili light?__________How long?______day(s)
Birth weight_______ Birth length_______Baby home on day_______ Days until birth Wt_____

Patient Name: Date:

Pediatric History
2 months to 2 years

The following questions are designed to help the doctor provide a detailed evaluation of your child.

Nutrition (please circle Y / N for the following questions)

Y / N Is your child still being breast fed? If no, for how long was he/she breast fed?__________
IF still breast feeding, how much dairy does the mother consume each day?___________
Y / N Is your child formula fed? Which formula or other milk source?______________________
Y / N Is your child eating solid food? What foods does his/her diet contain?________________
________________________What is your child's favorite food?_______________________
Y / N Does your child have any feeding difficulties?___________________________________
Y / N Does your baby click, have loud swallowing, suck in air during feedings?______________
Y / N Has your baby been diagnosed with tight oral tissue (ex: tongue tie)?________________
If so, by who__________________________Date revised____________________________
Y / N Does your child have any digestive disturbances?__________________________________
Y / N Does your child have daily bowel movements?____________________________________
Y / N Does your child have any food allergies?____
Y / N Does your child have any persistent or intermittent skin rashes?_____________________
Y / N Is your child receiving any vitamins or supplements?_______________________________

Trauma (please circle Y / N for the following questions)

Y / N Has your child had any recent falls or traumas?____________________________________
Describe the trauma and the date it occurred?______________________________________
Y / N Has your child ever fallen downstairs or fallen from any height?_____________________
Y / N Has your child ever been in a motor vehicle accident or near-miss?__________________
Y / N Has your child ever had a bone fracture or joint dislocation?_________________________
Y / N Has your child had any other trauma or injuries?__________________________________
Y / N Does your child ever bang his/her head repeatedly against a wall, bed or other object?____

Growth and Development (please circle Y / N for the following questions)

Y / N Can your child roll? At what age did your child start to roll?__________________________
Y / N Can your child sit unsupported? At what age did your child start to sit up?_____________
Y / N Is your child crawling? At what age did your child start crawling?____________________
Y / N Is your child walking? At what age did your child start to walk? ______________________
Y / N Does your child often trip and fall?____
Y / N Do you have any other concerns about your child's growth and development?__________
____

Patient Name: Date:

Health History (please circle Y / N for the following questions)

Y / N Has your child had colic?____

Y / N Has your child had any upper respiratory infections? How often?___________________

Y / N Has your child had asthma?____

Y / N Has your child ever complained of pains in the arms or legs?_______________________

Y / N Has your child ever complained of neck or back pain?____________________________

Y / N Has your child ever complained of headaches?_________________________________

Y / N Has your child had any earaches? At what age did they first occur?________________

Y / N How frequently does your child have earaches?_________________________________

Y / N Do your child's earaches tend to occur in the same ear? Is it right, left or both?________

Y / N Has your child had any other illnesses? Please list each illness and approx. date______
____

Y / N Is your child presently receiving any medication?________________________________

Y / N Has your child ever been to a hospital or emergency room for evaluation and treatment? Please explain:____

Y / N Has your child recently been vaccinated? Did he/she have any reactions to this?______
____

Y / N Do you have any other concerns about your child's health?_______________________

Doctors Notes:

Patient Name: Date:

Consent for Purposes of Treatment, Payment and Healthcare Operations

Congratulations on choosing chiropractic health care. This clinic believes in the safest, most natural health care possible.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks. It is not reasonable to expect any doctor to foresee all risks and/or complications and occurrence of these risks does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient, in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. For your information, the following is furnished to all patients who request and/or accept chiropractic care in this clinic. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiologic dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, and the chiropractic adjustment. The chiropractic adjustment is made to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are performed by hand, but may be performed by hand-guided instruments. You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. All health care procedures have some risks. With a chiropractic adjustment the most common risks are temporary aggravation of a condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, paraplegia, quadriplegia, brain damage, scars or burns associated with modalities performed, disc injuries or aggravation, and neurological deficits. The chance of these rare risks occurring is estimated by experts to be approximately only 1 per 1,000,000 treatments to 1 per 5,000,000 treatments. Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified of any positive findings. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. I hereby authorize providers at Natural Life Chiropractic to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. By signing below, I now agree to have chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

I consent to the use or disclosure of my protected health information by Natural Life Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Natural Life Chiropractic. I understand that diagnosis or treatment of me at Natural Life Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Natural Life Chiropractic is not required to agree to the restrictions that I may request. However, if Natural Life Chiropractic agrees to a restriction that I request, the restriction is binding on Natural Life Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Natural Life Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Natural Life Chiropractic's Notice of Privacy Practices prior to signing this document. Natural Life Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Natural Life Chiropractic. The Notice of Privacy Practices for Natural Life Chiropractic is also provided from the receptionist. This Notice of

Privacy Practices also describes my rights and Natural Life Chiropractic's duties with respect to my protected health information.

Natural Life Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Natural Life Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________	____________
Patient Name (Print)	Date
______________________________	____________
Patient Signature	Date
______________________________	____________
Parent/Guardian Signature	Date
______________________________	____________
Staff Witness	Date

Consent to Treat a Minor

Being the parent of legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter ______________________________ as the examining/treating doctor deems necessary. I understand and agree that I am responsible for the payment of all fees charged by this office for such care.

______________________________	____________
Parent/Guardian Name	Date
______________________________	____________
Parent/Guardian Signature	Date

Insurance Benefits

Natural Life Chiropractic is not contracted with any insurance provider, also known as "out of network" for PPO plans. Most insurance providers do offer out of network benefits. Out of network benefits may be the same as your in network, have a higher deductible, higher co-pay or both. As a courtesy, we can verify your benefits and bill for services should you have coverage. Verification of benefits is not a guarantee of payment. Therefore, we ask for all services to be paid in full until we receive an explanation of benefits (EOB) from your insurance. Any credit accumulated can be used for future appointments, supplements or reimbursed.

Natural Life Chiropractic cannot bill Medicare, Kaiser, Covered CA, Medi-Cal or HMO plans.

Insurance Provider: ____

Subscriber ID: __________________________ Group #: _________________________

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claims and also certify that all insurance information given to this clinic is correct and complete.

____________________________ ____________

Patient Name (Print) Date

____________________________ ____________

Patient Signature Date

Request for Payment of Benefits to Provider of Care

I hereby authorize _____________ Insurance Company/Insurance Administrator to pay by check, and for it to be made directly to Natural Life Chiropractic the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office by given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

____________________________ ____________

Patient Name (Print) Date

____________________________ ____________

Patient Signature Date

OFFICE POLICIES

Welcome to our family of patients. The following is a list of our office policies. The purpose of these policies is to enable our office to serve you and our community to the best of Natural Life Chiropractic's abilities. It is also our experience that patients who adhere to these policies benefit the most from the wonderful results of chiropractic care.

PURPOSE STATEMENT:
Our purpose is to educate, adjust, and assist as many families as possible toward optimal health and healing through natural chiropractic care.

REFERRALS:
Our office's success greatly depends upon referrals from satisfied patients who understand the benefits of optimal health and healing through chiropractic. We encourage all patients to share their experience at NLC with others, especially their family.

APPOINTMENT POLICY:
There will be a missed appointment fee ranging from $25.00 - $50.00 for ALL appointments canceled without 24-hour notice. The fee is determined upon the length of the appointment missed. If, for any reason, you are unable to keep an appointment, we require that you call/text/email us immediately to reschedule that visit.
Initial _______

In order to provide the best care possible to our patients, we require a reexamination should you have a lapse in care longer than 90 days. A reexamination may also be required for new injuries, complaints or symptoms to best evaluate your care. **Initial ________**

It is the patient's obligation to make up a missed appointment within 7 days of any cancellation. Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feel is best for you. Because your condition requires numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine. **Initial _______**

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results. Regardless of how many appointments are scheduled for you each week, please note that it is the *frequency* of visits that count, not the days on which you receive the service. **Initial _______**

When entering the office on any given visit, please go directly to the front desk and "sign-in." We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask. **Initial _______**

RETURNED CHECK FEE:
There will be a $25.00 fee charged for each returned check. Patient agrees to pay the full amount of the returned check(s) plus the $25 fee within ten days of notification by office personal. Payment must be made in cash.
Initial ________

PAYMENT OF ACCOUNTS:
Full payment is expected at the time of service unless prior arrangements have been made.
It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payors. All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service, or at the end of each week. Charges may also be made for missed appointments and those cancelled without 24-hour notice. **Initial ________**

I have read, understand and agree to the office policies as stated above.

____ ____________
Patient Signature Date

CREDIT CARD ON FILE POLICY:

Natural Life Chiropractic has implemented a credit card policy where we ask for a credit card which may be used later to pay any balance that may be due on your account. Co-pays are still due at the time of service. At check out, your credit card information will be obtained and kept securely in our processing system. The card on file can be used to process your charges for the day and/or any cancelled appointments fees. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

By signing below, I authorize Natural Life Chiropractic to keep my signature and my credit card information securely on-file in my account. I authorize Natural Life Chiropractic to charge my credit card for any outstanding balances when due.

____ ____________
Patient Signature Date

Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider's clinic or office or any other clinic or office whether signatories to this form of not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents, and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties’ consent to the intervention and joinder in this arbitration of any person of entity that would otherwise be a proper additional party in court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision:** All claims based upon the same incident, transaction of related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here __ . Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OF COURT TRIAL.
SEE ARTICLE 1 OF THIS CONTRACT.

____________________________________ ____________
Patient Signature Date

____________________________________ ____________
Patient Printed Name Date

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home/Cellular Telephone: _________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: _________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to mail to this fax number: _______________
- ☐ Email: ____

______________________________ ____________
Patient Name (Print) Date

______________________________ ____________
Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Natural Life Chiropractic.

______________________________ ____________
Patient Name (Print) Date

______________________________ ____________
Patient Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We create a record of the care and services you receive at our Office. We need this record to provide you with quality care and to comply with certain legal requirements.

How we may use and disclose medical information about you:
The following categories describe different ways that we use and disclose medical information without your specific written authorization:

- **For treatment:** We may use your medical information to provide you with medical treatment or services.
- **For payment:** We may use and disclose medical information about you so that the treatment and services you receive at Natural Life Chiropractic may be billed to and payment may be collected from you, an insurance company or health plan, or other third party.
- **For health care operations:** We may use and disclose medical information about you for Natural Life Chiropractic operations.
- **For appointments:** We may use your information to provide appointment reminders.

Special Situations which do not require your written authorization include: (1) Organ and Tissue Donation, (2) Military and Veterans Health Benefits, (3) Workers' Compensation, (4) Public Health Risks, (5) Health Oversight Activities, (6) Lawsuits and Disputes, (7) Law Enforcement, (8) Coroners, Medical Examiners and Funeral Directors, (9) National Security, Intelligence and Federal Protective Service Activities, (10) Inmates.

Authorizations for other uses and disclosures of medical information:
Other uses and disclosures of medical information not covered by the uses and disclosures stated above will be made only with your written authorization. If you give us an authorization, you may later revoke that permission in writing, at any time.

Your rights regarding medical information about you:
You have the following rights regarding medical information we maintain about you:

- **Right to inspect and copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care.
- **Right to amend:** If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information.
- **Right to an accounting of disclosures:** You have the right to request an "accounting of disclosures."
- **Right to request restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations.
- **Right to confidential communications:** You have the right to request communications of your health information by alternative means or at alternative locations.
- **Right to paper copies of electronic notices:** You have the right, where you have agreed to receive electronic notices, to obtain a paper copy of the notice upon request

Our legal duties:

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- We are required to abide by the terms of the notice currently in effect.
- We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain. Revised notices will be sent to all our patients within 20 days from the time such revisions are made.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with Natural Life Chiropractic or with the Secretary of the Department of Health and Human Services.

Contact:
To file a complaint with Natural Life Chiropractic, contact us at 714-256-2225.

Comprehensive privacy notice:
A more detailed, comprehensive notice regarding our privacy practices is available upon request to the person stated above.

Effective Date:
This notice is effective 03/01/2007.