St. Lucie Chiropractic Clinic

787 E Prima Vista Blvd
Port Saint Lucie, Florida 34953
772-878-3773
Fax 772-878-5783

Patient Information Sheet

Date: _____/_____/_____

Last _____ First _____ Middle _____

Nickname _____ Language _____ Birth Date _____/_____/_____ Age _____

Address _____ City _____ State _____ Zip _____

Social Security _____/_____/_____ Male ○ Female ○ Race _____ Ethnicity_____

Phone: Home_____ Work_____ Cell _____ Email Address_____

Married ○ Single ○ Divorced ○ Widowed ○

Emergency Contact Name _____ Emergency Contact Phone Number _____

Spouse Name / (Minor's Parent) _____

Occupation _____ Employer_____

Drug Allergies _____ _____ _____ _____ _____

Current Medications _____ _____ _____ _____ _____

What is your major complaint? _____

Other Complaints _____ Have you had similar conditions in Past? Yes ○ No ○

How long have you had this condition: _____? What activities aggravate your condition: _____

Is this condition getting progressively worse? Yes ○ No ○ Constant ○ Comes and Goes ○

Is this condition interfering with: Work ○ Sleep ○ Daily Routine ○ Other? ○

How long has it been since you felt good? _____. What do you believe is wrong with you? _____

List previous diagnosis and treatments you have received for present condition: _____

Highest Level of Education you received? GED/High School Diploma ○ Some College ○ Bachelor's Degree ○ Master Degree ○ PhD ○

Have you been in an Auto Accident? Past Year ○ Past 5 years ○ Over 5 years ○ Never ○

Have you had previous chiropractic care? Yes ○ No ○

List Surgical Operations and Dates _____

Type of Mattress _____ Age of Mattress _____

Are you wearing: Heel Lifts ○ Sole Lifts ○ Inner Soles ○ Arch Supports? ○

Are you on any special diet? Yes ○ No ○

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Family Health History

Many health problems are the result of hereditary spinal weakness; information about your family members will give us a better picture of your health

Have any family members had spinal disorders? Yes ○ No ○ Describe: _____

Name	Relation	Past and Present Health Problems

List below all conditions for which you have been treated in the past 10 years:

Have You Ever:	**Yes**	**No**	**Describe:**
Been knocked unconscious	○	○	_____
Used a cane, crutch or other support	○	○	_____
Been treated for a spine or nerve disorder	○	○	_____
Had a fractured bone	○	○	_____
Been Hospitalized other than surgery	○	○	_____
Do you:			
Take vitamins or minerals	○	○	
Think you need to take vitamins or minerals	○	○	

Date Of Last:	**Less than 6 months**	**6-18 months**	**Over 18 months**	**Never**
Last Immunization	○	○	○	○
Physical Exam	○	○	○	○
Blood Test	○	○	○	○
Chest X-Ray	○	○	○	○
Spinal X-Ray	○	○	○	○
Habits	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○

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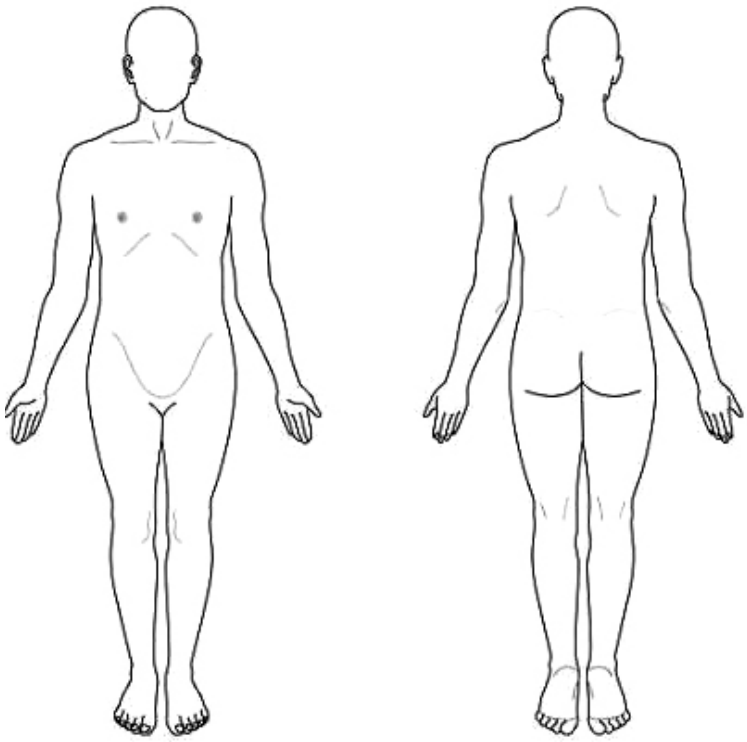
Date _____/_____/_____

Symptoms began on ____/ ____ /_____

Please Circle the quality of your current pain/problem (circle all that apply):

- Electric
- Sharp
- Stabbing
- Knife-Like
- Piercing
- Shooting
- Achy
- Griping
- Heavy
- Cramp-Like
- Burning
- Deep
- Superficial
- Stiffness
- Spasm
- Tearing
- Other _____

- ON THE BODIES, DRAW CIRCLES AROUND AREAS WHERE YOU HAVE PAIN.
- THEN DRAW AN ARROW TO INDICATE WHERE THE PAIN SPREADS TO.
- BE SURE TO INCLUDE ALL AREAS WHERE YOU HURT, WERE HURT, OR WHICH DON'T WORK AS A RESULT OF YOUR INJURY.



The center of my pain is easily identified? Yes ○ No ○

The boundaries of my pain are easily identified? Yes ○ No ○

I feel more pain in my leg(s) than in my lower back? Yes ○ No ○

I feel the Pain more in my arm(s) and or hand(s) than in my neck? Yes ○ No ○

Briefly Describe Your Symptoms:

_____

How Did Your Symptoms Start:

_____?

Average Pain Intensity Last 24hours (circle):	1	2	3	4	5	6	7	8	9	10
Average Pain Intensity Last Week (circle):	1	2	3	4	5	6	7	8	9	10
Average Pain Intensity At Its Best (circle):	1	2	3	4	5	6	7	8	9	10
Average Pain Intensity At Its Worst (circle):	1	2	3	4	5	6	7	8	9	10

How often do you experience your symptoms? Constantly ○ Frequently ○ Occasionally ○ Intermittently ○

How much have your symptoms interfered with your usual daily activities? (Including both work outside the home and housework)

Not At All ○ A Little Bit ○ Moderately ○ Quite A Bit ○ Extremely ○

How is Condition changing, since care began at this facility?

N/A Initial Visit ○ Much Worse ○ Worse ○ A Little Worse ○ No Change ○ A Little Better ○ Better ○ Much Better ○

In general, would you say your overall health right now is? Excellent ○ Very Good ○ Good ○ Fair ○ Poor ○

Has your pain spread down your leg(s) at some time in the last 2 weeks? Yes ○ No ○

Have you had pain in the shoulder or neck at some time in the last 2 weeks? Yes ○ No ○

In the last 2 weeks, I have only walked short distances because of my pain? Yes ○ No ○

In the last 2 weeks, I have dressed more slowly than usual because of my pain? Yes ○ No ○

It's really not safe for a person with a condition like mine to be physically active? Yes ○ No ○

Worrying thoughts have been going through my mind a lot of the time in the last 2 week? Yes ○ No ○

I feel that my pain is terrible and that it is never going to get any better? Yes ○ No ○

In general in the last 2 weeks, I have not enjoyed all things I used to enjoy? Yes ○ No ○

Overall, how bothersome has your pain been in the last 2 weeks? Not at all ○ Slightly ○ Moderately ○ Very Much ○ Extremely ○

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O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

I authorize Dr. Danielle Cossin, D.C. and Health And Abundance Inc. to give me reasonable and proper Chiropractic Care by today's standards.

Patient Signature_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent, The right to object to the use of my health information for directory purposes, and The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature Date

_____

Print Name

_____

Witness

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Patient Name _____

EXPLANATION OF NON-COVERED
CHIROPRACTIC SERVICES

DEDUCTIBLE:
Medicare requires you to pay a yearly deductible towards your medical expenses. If you have already been treated by other doctors this year, you may apply those bills to your deductible.

WHAT MEDICARE WILL PAY FOR:
After you have met your deductable, Medicare will reimburse you for 80 of your "allowable treatment charges". (The only "allowance treatment charge" for chiropractic is "manual manipulation of the spine".) According to current Medicare guidelines, extremities are not covered, that is: shoulders, knees, etc.

X-RAYS:
Medicare requires you to have current x-rays. "Current" means x-rays that are less than one year old. Medicare WILL NOT REIMBURSE you for x-rays and payments must be made by you.

EXAMINATIONS:
In order to determine the extent of your condition, as well as the type of treatment you need, the doctor will examine you prior to the initiation of treatment. Medicare WILL NOT REIMBURSE for this examination and payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS & SUPPORTS:
During the course of your treatment in this office, the doctor may determine that certain physical therapy, vitamin supplements and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare WILL NOT REIMBURSE you for any of these services and payments must be made by you.

ADVANCED NOTICE OF NON-COVERED SERVICES
(Required Language)

PHYSICIAN NOTICE
In accordance with the Medicare Act, Section 1842 (i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1842 (a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would other otherwise be covered, is not "reasonable and necessary", under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for:

Treatment plan: _____
The reason(s) for this denial is: Medicare considers further treatment "not medically necessary".

BENEFICIARY AGREEMENT

I understand that although the chiropractic services listed above may be required for treatment of my condition, these charges are NOT covered by Medicare and I will be personally responsible for payment.

I have been notified by my physician that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient's Signature_____ Date ____/____/_____

Witness_____

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REQUEST FOR RECORDS

Date:_____ To:_____
(Doctor/Hospital/Attorney)

Address:_____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my X-Rays, MRI reports, any other Diagnostic Procedures and records or copies of such and request that they be transferred to:

Dr. Danielle M. Cossin
Health and Abundance Inc.
787 E. Prima vista Blvd
Port St. Lucie Fl, 34952
Tel: (772) 878-3773
Fax: (772) 878-5783

Name of Patient _____

Date of Birth _____/_____/_____

ID#: _____

Date of Accident: _____/ _____/_____

Patient Signature: _____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (12) months unless another date is written here _____/____/_____

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Cancellation Policy/No Show Policy

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least **24** hours in advance you will be charged a twenty five dollar **($25)** fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is **15** minutes past their scheduled time we will have to reschedule the appointment.

3. Account Balances

We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over **$100** must make payment arrangements prior to future appointments being made.

_____ _____ ___/___/_____
Print Name Patient Signature Patient/Guardian Date

Patient Account #_____

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Walk-In Patient Policy

Patients are encouraged to make appointments for chiropractic services. Having an appointment enables us to have your medical chart available at the time of your visit, allows the clinician to review your information prior to your visit, and gives the staff an opportunity to properly schedule your visit.

Walk-in patients will be seen, but they may experience longer waits since patients with appointments will be seen first.

Arriving at least **15** minutes prior to your scheduled appointment time is encouraged so that your medical and financial information may be updated.

Every effort will be made to see patients with appointments within **15** to **30** minutes of the appointment time. However, difficult chiropractic cases, and complicated chiropractic procedures can cause delays.

Patient Form Completion Fees

• Permanent Disability Forms: **$ 50.00**

• Short Term Disability Forms: **$ 25.00** (includes completion of FMLA, as well as any required records & follow up forms to this incident)

• FMLA Paperwork: **$ 25.00**

• Handicap Parking Permit: **$ 10.00**

• Other Forms: Call Office

*** Patient must be current on office visits for forms to be completed. Please allow up to one week for pickup of completed forms.*

Medical Records Forms & Information

• Medical records will be sent to other physicians at no cost to patient after obtaining a valid medical record release from the patient.

• Patients requesting copies of medical records for personal use will be charged a copying fee of **$1.00** per page for the first **25** pages, then **$0.25** for each additional page. **Payment is required prior to records being released.**

• Please allow up to 48 hours for copies of records.

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations

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

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- 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

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct
- About criminal conduct on our premises
- In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:

    - Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record
    - Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
    - Protected health information involving laboratory tests when your access is required by law
    - If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
    - If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
    - Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
    - If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

    We may also deny a request for access to protected health information if:

    - A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
    - The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
    - The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

    If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:

    - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
    - Is not part of your medical or billing records
    - Is not available for inspection as set forth above
    - Is not accurate and complete

    In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:

    - To carry out treatment, payment and health care operations as provided above
    - To persons involved in your care or for other notification purposes as provided by law
    - For national security or intelligence purposes as provided by law
    - To correctional institutions or law enforcement officials as provided by law
    - That occurred prior to April 14, 2003
    - That are otherwise not required by law to be included in the accounting

6. You have the right to request and receive a paper copy of this notice from us.

7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.