7007 Wyoming Blvd. NE Suite A3
Albuquerque, NM 87109
505-822-5001

New Patient Paperwork

Date: _____/_____/_____

Name: ____ Social Security #: ____

Home Phone: ____ Cell Phone: ____

Address: ____

City: ____________________________________ State: _________________ Zip: ____________________________________

E-mail Address: ____ Fax # __________________________________

Age: _______ Birth Date: __________________ Gender: Male____ Female____ Race: ______________ Marital: M S W D

Occupation: ___________________________ Employer: ____

Employer's Address: _____________________________________ Office Phone: _____________________________________

Spouse: ____________________ Occupation: ________________ Employer: _______________________________________

How Many Children? ____________ Ages of Children: ____

Emergency Contact: ____Phone: __________________________________

Relationship to You: ____

How were you referred to our office? ____

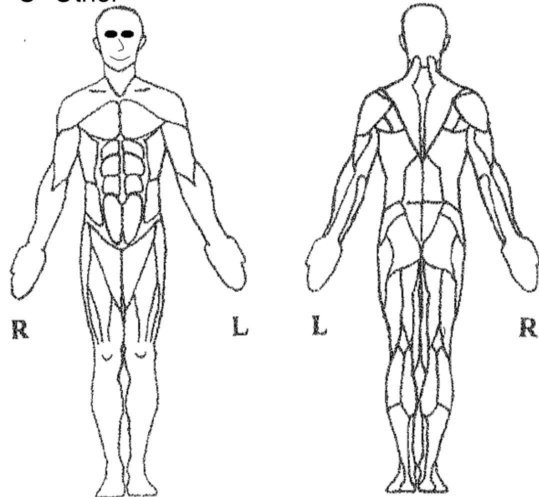
Family Medical Doctor: ____ Phone: ________________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS:

Chief Complaint (Why are you here): ________________
____
Date symptoms appeared: _____/_____/_____
Is this due to: ☐ Auto ☐ Work ☐ Other______________
Have you had this condition in the past? ☐ Yes ☐ No
If yes, when and describe: ________________________
____
Days lost from work: _____________________________
Date of last physical exam: ________________________
How frequent is the condition?
☐ Constant ☐ Frequent ☐ Intermittent
☐ Occasional ☐ Night Only
How long does it last? ☐ All Day ☐ Hours ☐ Minutes
Describe the pain:
☐ Sharp ☐ Aching ☐ Numbness ☐ Dull
☐ Tingling ☐ Burning ☐ Stabbing
☐Other________________________________
Is there anything you can do to relieve the problem?
☐ Yes ☐ No If yes, describe: ______________
____
If no, what have you tried that has not helped? ________
____
What makes the problem worse?
☐ Standing ☐ Sitting ☐ Lying ☐ Bending
☐ Lifting ☐ Twisting ☐Other____________
____
Have you seen other doctors for this condition?
☐ Yes ☐ No Type of treatment: _____________
If yes, Who? (name)_____________________________
Were you satisfied with your treatment? ☐ Yes ☐ No

Use the letters below to indicate the type and the location of your pain or problem:
A=Ache B=Burning N=Numbness
S=Sharp T=Tingling P=Pins and Needles
O=Other



Are there any other conditions or symptoms that may be related to your problem?
☐ Yes ☐ No
If yes, describe: _____________________
____
Are there other unrelated health problems?
☐ Yes ☐ No
If yes, describe: _____________________
____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from any of the following? (Place a check mark by conditions that apply to you.)

☐Broken or Fractured Bones
☐Osteoarthritis
☐Strokes
☐Cancer
☐Eating Disorder
☐Ulcers
☐Circulatory Problems
☐Epilepsy
☐Alcoholism
☐Coughing Blood
☐Pace Maker
☐Drug Addiction
☐High/Low Blood Pressure
☐Seizures/Convulsions
☐HIV Positive
☐Excessive Bleeding
☐A Congenital Disease
☐Gall Bladder
☐Ruptures
☐Depression
☐Diabetes
☐Tuberculosis
☐Asthma
☐Kidney Disease
☐Kidney Stones
☐Liver Disease
☐Mental Illness
☐Heart Disease
☐Lung Disease
☐Rheumatoid Arthritis
☐Chills
☐Unintentional Weight Loss
☐Fever
☐Night Sweats
☐Blurred Vision
☐Dizziness
☐Headaches
☐Slurred Speech
☐Numbness
☐Facial Weakness
☐Limb Weakness
☐TMJ Problems
☐Abdominal Pain
☐Blood Clots

Please explain any checked conditions: ____
____
____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain
Date of last Menses ____/____/____ My menses is Regular Irregular
Are you currently taking an oral contraceptive (birth control pill)? ☐ Yes ☐ No

Do you have a history of stroke or hypertension? □ Yes □ No

Have you had any major illness, hospitalization, injury, fall, auto accident or surgery? □ Yes □ No
If yes, explain: ____
____
Women, please include information about childbirth (include dates): ______________________________
Have you been treated for any health condition by a physician in the last year? □ Yes □ No
If yes, explain: ____
What medications or drugs are you taking? ____
Do you have any allergies to any medications, nutritional products or food? □ Yes □ No
If yes, describe: ____
Do you have any allergies of any kind? □ Yes □ No
If yes, describe: ____
Please list any other health problems you have, no matter how insignificant they may be: __________________
____

SOCIAL HISTORY:

Do you drink alcoholic beverages? □ Yes □ No If yes, how many drinks per week? ____________________
Do you use any tobacco products? □ Yes □ No If yes, what kind: ______________________________
Do you smoke? □ Yes □ No If yes, packs per day: ______________________________
Do you take vitamin supplements? □ Yes □ No If yes, please list: ______________________________
Do you consume caffeine? □ Yes □ No If yes, how much per day: __________________________
Do you exercise? □ Yes □ No If yes, what is the frequency and type of exercise? ______________
____
What are your hobbies? ____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ Sitting_____ Bending______ Working at a computer_______

FAMILY HISTORY:

Father: □living deceased
Current age if still living: ______ Cause of death and age at death if deceased: ________________________
Mother: □living deceased
Current age if still living: ______ Cause of death and age at death if deceased: ________________________
Check if applicable to you: □as an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? □ Yes □ No
If yes, please list: ____

FAMILY DISEASES: (Check if applicable and indicate Father, Mother, Sister, Brother):

□ Tuberculosis____
□ Cancer____
□ Mental Illness____
□ Diabetes ____
□ Asthma____
□ Heart Disease ____
□ Stroke ____
□ Kidney Disease____
□ Lung Disease____
□ Arthritis_____
□ Liver Disease _____
□ Other_____
Explain: ____________________________________
____
____
____

Patient Name: ____________________________

Signature: ______________________________

Date: ___________________________________

Guardian Name: __________________________

<u>Financial Policy</u>

Active Chiropractic Spine and Joint Center, LLC

Paul Hordes, DC

Amanda Lopez, DC

Danielle Fromer, LMT

We are committed to providing you with the best possible care and we are happy to discuss our professional fees with you at any time. Our goal is to put you back in control of your health and to provide you with high-quality healthcare at a reasonable fee. Your clear understanding of our financial policy is important to our professional relationship.

Private Payments:

Payments are expected at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and American Express. If there is a problem with payment, please let us know immediately. We do not want financial problems to interfere with your care.

Insurance:

We ask for payments at the time of service. We will gladly fill out the necessary insurance forms and file claims for you with insurance carriers that we are contracted with as in-network providers. We are unable to file claims for any insurance carriers that we are not in-network with. The patient is responsible for all referrals, co-payments, and deductibles where applicable. Please refer to your insurance company's agreement for chiropractic care benefits.

Personal Injury:

We will accept Med-Pay (medical coverage on your auto insurance policy) and Third-Party cases. You will need to provide our office with a claim number, the adjuster's phone number, and the automobile insurance company's billing address. Med-pay will cover your doctor's bill regardless of who was at fault. We will bill your auto-insurance company for prompt and direct payment for your care, up to your policy limits. If this is a Third-Party claim, we would prefer to have an attorney's Letter of Protection. Payment in full is expected upon case settlement. **The patient is ultimately responsible for any and all services rendered.**

Missed Appointments:

Please give our office a minimum of 24-hour notice for any cancellation or rescheduling of an appointment. It is our policy to bill the patient a fee of $30.00 if proper notice is not given. Special exceptions and emergencies will be taken into consideration. Our office books appointments several weeks in advance and has a long waiting list of patients hoping to be seen. Please be courteous to your fellow patients and help us to serve you better by keeping your scheduled appointments.

Check Return Policy:

If for any reason this unfortunate situation arises, the patient will be charged a $25.00 fee per occurrence.
I, _______________________________ understand and accept the above stipulations and acknowledge that I am financially responsible for the services rendered. I understand and agree that my insurance coverage is a contract between the insurance company and myself. I also understand that if I suspend or terminate my care and treatment, any balance for professional services rendered to me will be immediately due and payable. I also understand that any account 30 days past due will be subject to interest at 1.5% per month (18% annual) retroactively. I will be financially responsible for charges if a collection agency is utilized.

Responsible Party Signature: ____ Date: ______________________

Witness (office personnel): ____

<u>Notice of Informed Consent</u>

Active Chiropractic Spine and Joint Center, LLC
Paul Hordes, DC
Amanda Lopez, DC
Danielle Fromer, LMT

Every type of healthcare is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment or is restricted in their motion. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A Subluxation has also been described as an incomplete dislocation of a joint, and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral Subluxation with spinal manipulation, (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments and create normal joint movement. Frequently, adjustments create a popping or clicking sensation in the area being treated.

In our office, we use highly trained staff to assist the doctor with portions of your consultation, examination, x-rays, physiotherapy, traction, massage, exercise instruction, and other treatments. Occasionally, when your doctor is not available, another clinic doctor will be available to treat you in their place.

Stroke: There is a remote chance (1:6,000,000) of a rare type of stroke associated with manipulation of the cervical spine. We take particular care to avoid this type of manipulation.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally these treatments can irritate this problem. To help prevent this, patients are put through specific tests and procedures during the examination to see if the treatment might aggravate disc symptoms. Complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, chiropractic adjustments, traction, massage, and other treatments may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution with no long-term effects on the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle back. They extend from your back to the front of the chest. Rarely, a chiropractic adjustment may break a rib. This is referred to as a fracture. While this can occur in any patient, this usually occurs only in those patients with weakened bones from conditions such as osteoporosis, prolonged steroid use, or other bone-weakening diseases. <u>Let your doctor know if any of these apply to you.</u> We adjust all patients carefully, especially those with bone-weakening conditions. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of electricity, light/laser therapy, heat, and ice in the office, and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely, electricity, light/laser therapy, heat, or ice can irritate the skin. The result is a temporary increase in skin pain and possibly some blistering or burning. These problems

also occur so rarely that there are no available statistics to quantify their probability. If you ever feel any discomfort during treatment, immediately inform a staff member to prevent any unnecessary injury.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell the doctor or a staff member about it.

Other Problems: There may be other problems or complications that arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options, or refer you to another healthcare provider for alternative types of treatment.

If you have any questions about the above information, please ask your doctor to explain them in more detail. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize Dr. Paul Hordes, DC, and Dr. Amanda K. Lopez, DC, and whomever he or she designates to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary based on the findings during the set course of treatment.

Patient Signature: ______________________________ **Date: ________________________**

Patient Name: _________________________________ **Witness: ______________________**

Consent for Treatment of a Minor: I, the undersigned, hereby authorize Dr. Paul Hordes, DC, and Dr. Amanda K. Lopez, DC, and whomever he or she designates to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary based on the findings during the set course of treatment to:

Minor Child's Name: ___________________________ **Parent/Legal Guardian: ______________________________**

Authorization Form

Active Chiropractic Spine and Joint Center, LLC
Paul Hordes, DC
Amanda Lopez, DC
Danielle Fromer, LMT

Authorization is hereby granted to Dr. Paul Hordes, DC and Dr. Amanda K. Lopez, DC to release any information that is acquired during my examination and treatments to any insurance company, attorney, or adjuster. I, ______________________ authorize and assign direct payment to Active Chiropractic Spine & Joint Center, LLC and Dr. Paul Hordes, DC of any sum I now or hereafter owe this office by my attorney out of the proceeds of any settlement of my case and/or by an insurance company obligated to reimburse me for the charges of these services.

I clearly understand and agree that health and accidental insurance policies are an arrangement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment, and I agree to pay all billing on a timely basis. I also understand that any amount authorized to be paid directly to this office will be applied to any outstanding balance that I owe.

I understand that in personal injury cases, payment may be deferred until settlement, with the total due in full at settlement, providing that no other insurance is involved and if an attorney approved by this office is representing me.

I further understand that if I suspend or terminate my treatment in this office, or if I discharge my attorney or he/she discontinues my representation, any fees for professional services rendered to me will be **immediately due and payable**. I also agree to pay any and all reasonable legal fees and court costs incurred on the collection of this account.

Limited Power of Attorney: I hereby grant to the physician/facility named above the power to endorse upon any checks, drafts, or other negotiable instrument representing a payment from any insurance company or attorney's office for payment of treatment and health care rendered by the physician/facility. I agree that any insurance payments representing any amount in excess of charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

Patient Signature: _________________________ **Minor's Name:** ________________________

Witness: _________________________________ **Parent/Guardian:** ____________________

Date: ____________________________________

Insurance Policy

Active Chiropractic Spine and Joint Center, LLC
Paul Hordes, DC
Amanda Lopez, DC
Danielle Fromer, LMT

We are committed to providing you with the best possible care and will gladly answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and your insurance company. We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. Assisting in the filing of claims is a courtesy that we extend to our patients. Ultimately, all charges are your responsibility from the date the services are rendered.

Payment for services is due at the time the services are rendered. We will be happy to submit claims to your insurance company for payment. However, you are ultimately responsible for any unpaid balances.

Missed Appointment Policy

Broken or missed appointments are a loss to everyone. If you are unable to keep your appointment, please give our office 24 hours advance notice. Without notice, there will be a

$30.00 missed appointment fee!

(This is not billable to insurance)

Patient Signature: ______________________________ Date: ___________________________

Permissions and Contact Information

Active Chiropractic Spine and Joint Center, LLC

Paul Hordes, DC

Amanda Lopez, DC

Danielle Fromer, LMT

I agree to receive text messages and phone calls to the home phone and cell phone numbers listed on pg. 1 of this New Patient Paperwork for appointment reminders and billing information. Active Chiropractic Spine and Joint Center, LLC may also leave voice messages at the same listed numbers for appointments and billing information.

_______________________________________ _____________________________________

Signature Date

If Active Chiropractic Spine and Joint Center, LLC is unable to reach me by phone or text, they may contact the following person/people regarding appointments and billing, and may leave text and voice messages at these numbers.

1)______________________________ ___________________ _____________________________________

Name Phone # Relationship to patient

2)______________________________ ___________________ _____________________________________

Name Phone # Relationship to patient

If Applicable: I give permission for my minor child, _____________________ who is under the age of 18, to be treated by Active Chiropractic Spine and Joint Center in my absence. Furthermore, I give the following person/people permission to accompany my child to their appointment and to relay pertinent information to me regarding my child's treatment and care during the following time period:

From_________________ To _________________ ____________________________ ___________________

Signature Date

1)_________________________ ___________________ _____________________________________

Name Phone # Relationship to patient

2)_________________________ ___________________ _____________________________________

Name Phone # Relationship to patient

If Applicable: I give permission to my minor child, ___________________, who is over the age of 15, to attend and receive treatment at Active Chiropractic Spine and Joint Center without my being present during the following time period:

Start date: ________________________ End date: ______________________

_________________________________ ______________________________

Signature Date

Massage Consent
Active Chiropractic Spine and Joint Center, LLC
Danielle Fromer, LMT

I understand that the massage I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used, including cupping, can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis, and I should see a healthcare provider for those services. Because massage should not be performed under some circumstances, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist from any liability if I fail to do so.

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. I acknowledge that I am aware of the risks involved in receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

______________________________ ______________________________
Patient Signature Date

____
Printed Name

______________________________ ______________________________
Therapist Signature Date

____
Printed Name

Dry Needling Consent
Active Chiropractic Spine and Joint Center, LLC
Paul Hordes, DC
Amanda Lopez, DC

Potential risk of Physical therapies includes exacerbation or lack of progress in the following areas: Symptoms (pain, numbness/tingling), swelling, range of motion, strength, and/or function. Benefits include improvements in the treatment areas. Other specific risks and benefits vary by condition, and you will be provided information and every opportunity to ask questions. With any service offered, you maintain the right to decline a treatment or intervention at any time.

Dry Needling (DN)
DN is a technique that involves the insertion of needles similar to acupuncture needles (without medication) to promote healing within the body. Dry Needling works by changing the way your body senses pain (neurological effects), and by helping the body heal itself. There are additional electrical and chemical changes associated with dry needling therapy which assist in the healing process. It is important to understand that dry needling may act as just one part of your overall rehabilitative treatment. Treatment techniques are based on concepts of modern medicine and are not to be considered acupuncture or meridian therapy. Risk of injury and/or potential complications could result from DN if proper precautions are not observed. If you are being treated in the shoulder, neck, back, or chest area there is an additional risk that involves your lung. If the lung itself is punctured, you may develop a condition called Pneumothorax, or a collapsed lung. This is a rare but serious problem, and you should go directly to the hospital ER department without panicking if it occurs. The symptoms of this event include shortness of breath, a bluish tinge to your lips, and an inability to "catch your breath". In general, there is very little risk associated with this technique if performed properly by a trained practitioner.

- You may feel sore immediately after treatment in the area of the body you were treated. This is normal, but does not always occur. It can also take a few hours, or until the next day before you feel soreness. The soreness may vary depending on the area of the body that was treated. It also varies from person to person, but typically it feels like you had an intense workout at the gym. Soreness typically lasts 24-48 hours. If soreness continues beyond this, please contact our office.

- It is common to have bruising after treatment, or even a small drop of blood may surface on the skin after treatment. Some areas are more likely than others to develop this. Some common areas are the shoulders, base of the neck, head, face, arms, and legs. Large areas of bruising rarely occur, but can. Use ice to help decrease the bruising, and if you feel concerned, please contact our office.

- It is common to feel tired, nauseous, emotional, giggly or "loopy", and/or somewhat "out of it" after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond one day, contact our office as a precaution.

- There are times when treatment may make your symptoms worse. This can be a normal response. If this continues past the 24–48-hour window, keep note of it, as this is helpful information, and your provider will then adjust your treatment plan based on your report, if needed. This does not mean DN cannot help your condition.

Complications that could result from Dry Needling:
Bleeding / Bruising / Local infection / Nerve injury

Dry Needling treatment may produce the following during the treatment, which are usually temporary:
Pain / Swelling / Nausea / Anxiety / Dizziness / Referral of pain of muscle twitch

Post Dry Needling effects may be:
Muscle soreness / Muscle tightness / Paresthesia / Joint stiffness

Patient Signature: ____

Printed Name: ____

Date: ____

Practitioner Signature: ____________________________________

Active Chiropractic Spine & Joint Center, LLC
7007 Wyoming Blvd. NE Suite A-3
Albuquerque, New Mexico 87109
PH: 505-822-5001

Notice of Patient Privacy Policy

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.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Paul Hordes

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.activeABQ.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the

disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

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

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **<u>Required Uses and Disclosures:</u>** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **<u>You have the right to inspect and copy your protected health information.</u>** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **<u>You have the right to request a restriction of your protected health information.</u>** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location.</u>** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **<u>You may have the right to have your doctor amend your protected health information.</u>** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***<u>You have the right to be notified by our office of any breech of privacy of your Protected Health Information.</u>***

- **<u>Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.</u>**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C**omplaints**

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us.

To file a complaint you may go to: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Paul Hordes. You may contact our Privacy Officer or any staff member, including Amanda K. Lopez, at the following phone number: 505-822-5001 or on our website: www.activeABQ.com for further information about the complaint process.

This notice was published and becomes effective on January 1, 2023