Patient Intake Form

ACTIVE LIFE CHIROPRACTIC, LLC
Nichole A. Lehman, DC
1900 East Market Street, Suite 2, York, Pennsylvania 17402
Phone: (717) 751-0500 FAX: (717) 814-5407

Title: ☐Dr. ☐Mr. ☐ Mrs. ☐ Ms. ☐Miss Gender: _____ Date: _____/_____/_____

First Name: _____ MI:____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____.

Preferred Phone Number: ☐Home ☐Cell ☐Work Email: _____

Social Security: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____

How would you prefer to be contacted for reminders? ☐Text ☐Email

Race: (check one)
☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other ☐Declined

Ethnicity: (check one)
☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Preferred Language:
☐English ☐Spanish ☐Other_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Employer:
Employment Status: ☐ Employed: ☐FT/☐PT ☐Student: ☐FT/☐PT ☐Retired ☐Homemaker ☐Unemployed ☐Disabled

Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Job Title/Position: _____ Description: _____

Insurance Information

☐Insurance ☐Worker's Comp ☐Self-Pay ☐Personal Injury/Auto☐ Other (please explain): _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy Number: _____ **Group#** _____ **Policy Number:** _____ **Group#** _____

Relation to Insured: Self/Spouse/Parent/Child/Other
If Other Than Self
Insured's Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other
If Other Than Self
Insured's Name: _____

Address: _____ City: _____ Address: _____ City: _____

State: _____ Zip: _____ DOB: _____/_____/_____ State: _____ Zip: _____ DOB: _____/_____/_____

Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____.

Primary Care Doctor/Practice: _____ Phone: (____) _____.

How did you hear about our office? _____

Signature: _____ **Date:** _____/_____/_____

Your Name_____ DOB _____ Today's Date_____

Symptoms and Present State of Health

Present Complaint/Reason for seeking care in this office _____

When did your problem begin? _____ How did your problem/complaint begin? _____

How would you describe your discomfort? (circle all that apply) Sharp Dull Ache Burning Pinching Stiff

Constant Intermittent Other _____

Do your symptoms radiate, shoot or travel in your body? Where? _____

Are you experiencing numbness/tingling in any area of your body? Where? _____

Since it began, is your problem: Same Better Worse

What aggravates or makes your problem worse? _____

What lessens or makes your problem better? _____

Is this problem worse during certain times of the day? _____

Does this condition interfere with (circle all that apply) Work Sleep Routine Other_____

Please list any other health practitioners you have seen for this condition and when seen

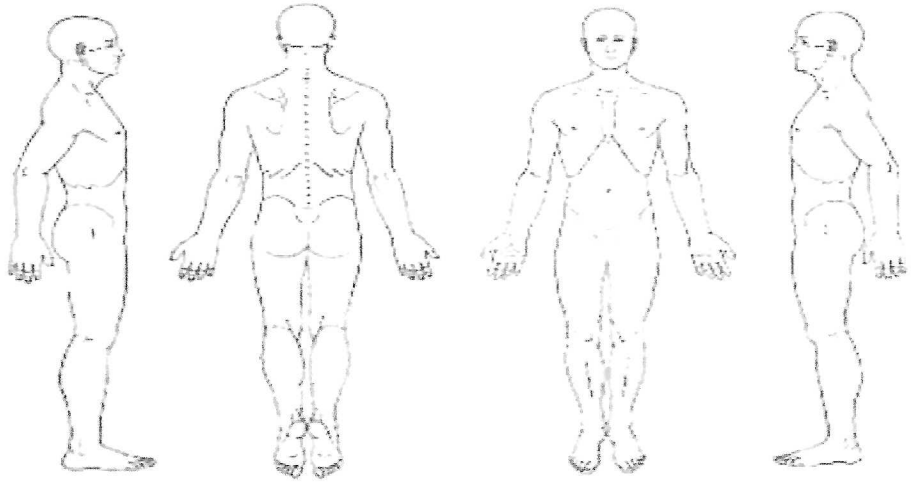
_____

Any home remedies _____ Do they help? _____

Please rate your pain by circling the number on the scale

(No complaint/ pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain imaginable)

Using the symbols below, mark on the pictures where you feel the pain.



Are you under medical care for any condition? If yes, please explain _____

What medications are you taking and for how long? _____

Please list any surgeries you have had and when _____

Is there a family history of: Heart Disease Arthritis Cancer Diabetes Stroke Other

If yes, please explain _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__Convulsions
__Dizziness
__Fainting
__Loss of Balance
__Fatigue
__Depression
__Headache
__Nervousness
__Irritability
__Tension
__Numbness

MUSCLES & JOINTS
__Low Back Pain
__Pain between shoulders
__Neck problems
__Arm or Hand problems
__Leg or Foot problems
__Jaw/TMJ problems
__Painful joints
__Stiff joints
__Sore muscles
__Weak muscles
__Walking problems
__Sprains/Strains
__Broken Bones

CARDIOVASCULAR
__High Blood Pressure
__Heart Attack
__Pain over the heart
__Poor Circulation
__Rapid Heart Rate
__Slow Heart Rate
__Strokes/TIA's
__Swelling in Ankles
__Varicose Veins
__Cold Feet/Hands

MENTAL/EMOTIONAL
__Anxiety
__Depression
__Anger/Aggression
__Attention Deficit
__Other_____

HABITS
__Smoking, what kind and how much _____
__Alcohol drinks/week_____
__Caffeine-Coffee/Tea/Energy Drinks Amount_____
__Stress Level Low Moderate High
__Exercise _____ Days/week What type of exercise_____

EAR/NOSE/THROAT
__Earache
__Enlarged Thyroid
__Frequent Colds
__Hay Fever
__Nasal Blockage/Deviated Septum
__Nose Bleeds
__Pain Behind Eyes
__Poor Vision
__Sinusitis
__Sore Throats
__Tonsilitis

GASTRO-INTESTINAL
__Stomach upset
__Frequent Belching/Gas
__Colon Problems
__Constipation
__Excessive Hunger
__Excessive Thirst
__Gall Bladder/Liver problems
__Nausea
__Abdominal Pain
__Ulcer
__GERD/Reflux/Heartburn
__Poor Appetite
__Poor Digestion
__Foods Not Fully Broken Down
__Vomiting
__Vomiting Blood
__Black Stool
__Bloody Stool
__Coating on Tongue
__Foul Breath/Halitosis
__Diarrhea
__IBS
__Crohn's
__Alternate Constipation/Diarrhea
__Loss of Smell or Taste
__Overly Sensitive to Smells

RESPIRATORY
__Asthma
__Chronic Cough
__Emphysema
__Spitting Blood
__Spitting Phlegm
__Allergies

GENITO-URINARY
__Blood in Urine
__Frequent Urination
__Urinary Tract Infections
__Kidney Infection
__Painful Urination
__Prostate Problems
__Loss of Bowel or Bladder Control

SKIN CONDITIONS
__Acne
__Boils
__Bruise Easily
__Eczema/Rash/Dermatitis
__Hives
__Itching frequently
__Sensitive Skin
__Dry Skin
__Hair Loss
__Too much hair

WOMEN
__Birth Control_____
__Cramps/Backache with Menstrual Cycle
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Miscarriage
__Infertility
__Painful Periods
__Vaginal Discharge
__Breast Pain
__Breast Lumps
__Fibrocystic Breasts
__# of Pregnancies _____
__# of Children_____
__Menopause, when started _____

MEN
__Testicular Problems/Pain
__Erection Difficulties
__Prostate Problems

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

PATIENT SIGNATURE_____ DATE _____

FINANCIAL POLICY

Nichole Lehman, DC / Active Life Chiropractic / 1900 E. Market St., Suite 2, York, PA 17402
Phone: (717) 751-0500 Fax: (717) 814-**5407**

Nichole Lehman, DC / Active Life Chiropractic believes that part of a good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT: Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or driver's license due to the many cases of identity theft.

INSURANCE: We are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed and are responsible for the balance in full. If we later receive payment for your insurer, we will refund any overpayment to you.

If **Nichole Lehman, DC / Active Life Chiropractic** is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, you are expected to pay charges due at the time of service. Our office will provide you with a receipt that you may submit to your insurance company to request reimbursement. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the office is closed may be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

LATE CHARGES: Invoices are due and payable upon receipt. There will be a $15.00 rebilling charge on each monthly statement issued after 30 days. If your account remains delinquent after 3 billing cycles, your account will be turned over to collections.

RETURNED CHECKS: Returned checks will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in York County.

ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORMS FEES: Completing insurance forms, copying medical records, etc., requires office staff time and time away from patient care for our doctor. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $25.00 per occurrence plus any applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records that are not based on a flat-rate charge are $1.46 per page for pages 1 through 20, $1.08 per page for pages 21 through 60, and $0.36 per page for pages 61 and up in accordance with the Department of Health Medical Records Fees. Active Life Chiropractic will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

FINANCIAL POLICY

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BILLING OFFICE: If you have questions regarding any of your billing statements, our staff at Active Life Chiropractic is available to assist you on Mondays, Wednesdays or Fridays. **Call (717) 751-0500.**

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for charges not covered by the assignment of insurance benefits.

CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25.00 missed appointment fee. New patient appointments will be subject to a $100.00 missed appointment fee. If a new patient misses two new patient appointments, you will no longer be accepted into the practice.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **Nichole Lehman, DC / Active Life Chiropractic** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Nichole Lehman, DC / Active Life Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Nichole Lehman, DC / Active Life Chiropractic. I authorize Nichole Lehman, DC / Active Life Chiropractic to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

INSURANCES WE DO NOT ACCEPT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for payment of charges at the time of service and that Nichole Lehman, DC / Active Life Chiropractic will offer to provide me with a receipt that I may use to submit to my insurance company to request direct reimbursement for any applicable services.

SELF PAY PATIENTS: Our office has reasonable rates for all Point of Service (POS) patients. Patients who are POS are required to pay at the time of service as per insurance regulations. Charges for supplies and Quest Lab tests are due and payable upon receipt. Nichole Lehman, DC / Active Life Chiropractic does not make payment arrangements or extend credit. All services and supplies are expected to be paid in full at the time of service.

RELEASE OF INFORMATION: I hereby authorize and direct **Nichole Lehman, DC / Active Life Chiropractic** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____
Please print the name of the **patient.**

INFORMED CONSENT

Nichole A. Lehman, DC
1900 East Market Street, Suite 2, York, Pennsylvania 17402
Phone: (717) 751-0500 FAX: (717) 814-5407

To The Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign anything that is unclear.

The Nature of the Chiropractic Adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use those procedures to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: AS a part of the analysis, examination and treatment, you are consenting to the following procedure: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies, palpation, orthopedic testing, postural analysis, hot and cold therapy, vital signs, basic neurological testing, electrical muscle stimulation, traction, decompression, exercise and stretches.

The Material Risks Inherent in Chiropractic Adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and any X-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options: Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Nichole Lehman, DC, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name (Print) _____

Patient's Signature _____ Date _____

Signature of Parent or Guardian (if a minor)_____ Date _____

Authorized Facility Signature _____ Date _____

HIPAA Notice of Privacy Practices **Updated: May 16, 2023**
Active Life Chiropractic 1900 E. Market St, Suite 2, York, PA 17402

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
If you have any questions about this notice, please contact our office (717) 751-0500
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Our Obligations
We are required by law to:
- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information
Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's Office Manager.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the chiropractic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health 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 Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Office Manager.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Office Manager.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Office Manager.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Office Manager. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Office Manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice. We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints
If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Active Life Chiropractic
1900 East Market Street, Suite 2
York, Pennsylvania 17402
Phone: (717) 751-0500 FAX: (717) 814-5407

Patient Name: _____ **DOB:**____/____/____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION
HIPAA NOTICE OF PRIVACY PRACTICES

I, the undersigned, have read the *HIPAA Notice of Privacy Practices* policy of Active Life Chiropractic and agree to its terms. I am also acknowledging that I have been offered a copy of this notice, and have received a copy upon my request.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature (if patient is under 18 years of age)