Health History Questionnaire

I. General Patient information

Date: ____/____/____ Name: _____

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

County:_____ Marital Status: _____

Preferred Phone_____ (H/C/W) Secondary Phone: _____ (H/C/W)

Age: _____ Date of Birth____/____/____ Place of Birth: _____

Guardian (If under 18):_____

Height: _____'_____" Weight: _____lbs.

Email:_____

Driver's License Number:_____

Occupation: _____ Employer:_____

Employer Address: _____ City:_____

State: _____ Zip:_____

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

Main concern: _____

How does this problem affect your daily activities?_____

When did you first notice symptoms? _____

If you have been diagnosed, what is the diagnosis?_____

What kinds of treatment or therapies have you tried?_____

Results: _____

Any medications:_____

Supplements:_____

Allergies: _____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	_____
2.	☐	☐	☐	☐	_____
3.	☐	☐	☐	☐	_____
4.	☐	☐	☐	☐	_____
5.	☐	☐	☐	☐	_____
6.	☐	☐	☐	☐	_____
7.	☐	☐	☐	☐	_____
8.	☐	☐	☐	☐	_____
9.	☐	☐	☐	☐	_____
10.	☐	☐	☐	☐	_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)

☐ HIV/STD ☐ Pap smear ☐ Mammography

☐ Other:_____

Test Results and Date:_____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding tendency
☐ Syphilis	☐ Measles	☐ Chicken pox	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High blood pressure
☐ other lung illnesses	☐ other liver illnesses	☐ other heart illnesses	☐ other kidney illnesses
☐ other spleen illnesses		☐ other stomach illnesses	

☐ other: _____

Immunizations: _____

Surgeries: _____

III. Family History

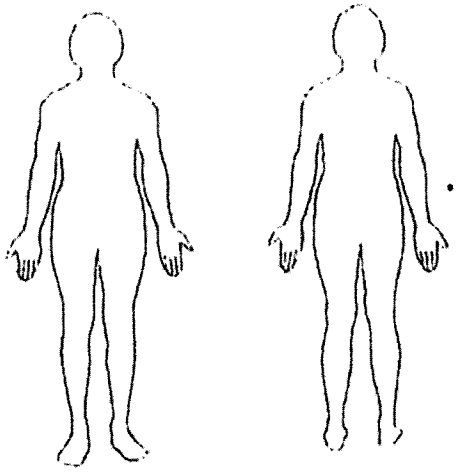
Family member	Alive	Deceased	Present health or cause of death
Father	☐	☐	
Mother	☐	☐	
Spouse	☐	☐	
Children	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Sister	☐	☐	
Sister	☐	☐	
Sister	☐	☐	

Where are you in the birth order? ☐ first ☐ last ☐ middle ☐ only
Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding tendency
☐ Kidney disease	☐ Alcoholism	☐ Nervous Illness	☐ Mental illness
☐ Stroke	☐ Other_____		

IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Front Back

Is the pain:
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other:_____

Do the following lessen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other:_____

Do the following worsen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Other:_____

Please check the following that pertain to you:

Overall Temperature (Kidney function):
☐ Cold hands
☐ Cold feet
☐ Sweaty hands
☐ Sweaty feet
☐ Hot body temperature (sensation)
☐ Cold body temperature (sensation)
☐ Afternoon flushes
☐ Night sweats
☐ Heat in the hands, feet, and chest
☐ Hot flashes any time of the day
☐ Thirsty
☐ Perspire easily
☐ Lack of perspiration

- ☐ Take water to bed
- ☐ Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):
- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open in the daytime
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

Blood (Liver, Spleen, Heart function):
- ☐ Dizziness
- ☐ See floating black spots

Heart function:
- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Drink coffee (# of cups per week: _____)

Lung function:
- ☐ Nasal Discharge (Color: _____)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies (To what?_____)
- ☐ Alternating fever and chills
- ☐ Sneezing
- ☐ Headache (Location: _____)
- ☐ Overall achy feeling in the body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# of cigarettes per day: _____)
- ☐ Sadness
- ☐ Melancholy

Spleen function:
- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Prolapsed organs (previously diagnosed, which organ? _____)
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
- ☐ Loose
- ☐ Constipated
- ☐ Incomplete
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

Dampness trapped in the body:
- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess

- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

Stomach function:

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad breath
- ☐ Mouth (canker) sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach pain
- ☐ Vomiting

Liver, Gall Bladder function:

- ☐ Alternating diarrhea and constipation
- ☐ Chest pain
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Frequently unable to adapt to stress (What causes the stress? _____)
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Limited Range-of-Motion, Neck
- ☐ Shoulder tension
- ☐ Limited Range-of-Motion, Shoulder
- ☐ Drink alcohol
- ☐ Recreational drugs (Which? _____, How much per week? _____)
- ☐ High-pitched ringing in the ears
- ☐ Gall stones (history or current)
- ☐ Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Urinary Bladder function:

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake during the night twice or more to urinate

☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination:
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning
☐ Painful

☐ Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Libido:
☐ Normal
☐ High
☐ Low

Other symptoms:

Women only:

Regular menstrual cycle? ☐ Y ☐ N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
cycle:_____

Pregnant? ☐ Y ☐ N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire

	Severe	Moderate	Slight	Normal
Vaginal discharge:	☐	☐	☐	☐
Bleeding between periods:	☐	☐	☐	☐

Do you experience any of the following pre-menstrual syndromes?

☐ nausea ☐ food cravings ☐ depression ☐ vomiting
☐ headaches ☐ irritability ☐ water retention ☐ migraines
☐ anxiety ☐ breast swelling ☐ breast tenderness
☐ other emotions:_____ ☐ dull pain, where?_____
☐ sharp pain, where?_____
☐ Other: _____

Please fill in the following menstrual chart: (even if you do not have periods.
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

	Severe	Moderate	Slight	Normal
☐ Swollen testes	☐	☐	☐	☐
☐ Testicular pain	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐
☐ Premature ejaculation	☐	☐	☐	☐
☐ Feeling of coldness or numbness in external genitalia	☐	☐	☐	☐
☐ Other_____	☐	☐	☐	☐

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____

Informed Consent Form

Please read this entire document carefully prior to signing. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

Is Acupuncture safe?

Yes, but the common side effects of an acupuncture treatment are listed below.

- Drowsiness may occur after a treatment. If you are so affected, you are advised not to drive.
- Minor bleeding or bruising may occur when the needles are removed.
- Indwelling ear needles can become painful or inflamed. If this occurs, promptly remove the needle(s) involved.
- Symptoms can get worse after a treatment. Be sure to tell your doctor about this at your next appointment.
- Fainting may occur in certain patients, particularly at the first treatment.

Cupping and Gua Sha

- These techniques may cause redness and petechiae (small red/purple bumps). This is a normal presentation and no other action needs to be taken
- The redness and bumps will dissipate typically within 1-3 days, but can take up to a week.

Moxibustion

- A burn may occur during the use of moxibustion. This is rare, but can happen
- Notify the doctor if a burn shows up after treatment.
- Always let the practitioner know if the moxibustion is getting too hot

In addition, if there are particular risks that apply in your case, your doctor will discuss these with you.

Is there anything your doctor needs to know?

Apart from the usual medical details, it is important to tell you doctor.

- If you have ever become faint or had a seizure,
- If you have a bleeding disorder,
- If you are taking anticoagulants or any other medication,
- If you have a damaged heart valve, a pacemaker or other cardiac problem,
- If you have any other particular risk of infection.

Statement of Consent
I confirm that I have read and understood the above information. I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.
Signature
Print Name Date

Only single-use, sterile, disposable needles are used in the clinic.

Center for Chiropractic & Wellness
Patient Missed Appointment Policy

Definitions:
Policy—a method or course of action designed to influence and determine decisions/a guiding principle or procedure.
Appointment—a meeting with someone at a certain time or place
Missed—fail to keep, do, or be present at

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results.

If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in you life so that this can occur.
2. If you become ill, we still want you to come in, because your treatment will help you recover.
3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment
4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change the appointment.
5. All canceled or missed appointments must be rescheduled and made up within 1 week.
6. Service charges for missing an appointment are as follows:

Dr. Jennifer Greenfield: AK/NET/NAET
15 Minute Appt. $30.00
Dr. Monique Santoro L.Ac.
Acupuncture Initial Consult $25
1 Hour Treatments $40
Dr. Jennifer Greenfield, Dr. Kira Cervenka
15 min. Chiropractic Appointment $40
30 min. Chiropractic Appointment $60
Kathy Wilson L.M.B.T
1 hour massage $35
Ion Cleanse:
Cleanse Treatment $25

**** Patients with packages will have one treatment deducted from their package for each 15 minute time slot.**

* Note: Confirmation calls are made the day before each patient's appointment. These calls are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call does NOT validate a missed appointment.

I have read and understand the above policy

Patient's Name: _____ Signature: _____

Doctor's Signature: _____

Consent for Purposes of Treatment, Payment And Healthcare Operations

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

I consent to the use or disclosure of my protected health information by Center for Chiropractic & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Center for Chiropractic & Wellness. I understand that Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T may refuse to diagnose or treat me, if I do not consent to the disclosure of my protected health information for the purposes stated above. (My signature on this document is evidence of this consent).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Chiropractic & Wellness is not required to agree to the restrictions that I may request. However, if Center for Chiropractic & Wellness agrees to a restriction that I request, the restriction is binding on Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T.

I understand I have a right to review Center for Chiropractic & Wellness' Notice of Privacy Practices prior to signing this document. Center for Chiropractic & Wellness' Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Center for Chiropractic & Wellness. The Notice of Privacy Practices for Center for Chiropractic & Wellness is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Center for Chiropractic & Wellness duties with respect to my protected health information.

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

I have the right to revoke this consent, in writing at any time, except to the extent that Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T. have taken action in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Center for Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

Notice of Privacy Practices

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

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

Our Privacy Officer is Alicia Kerins

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. "Protected Health Information" (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."Click & Type" , 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 chiropractic 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 chiropractic students.

  For example, we may disclose your protected health information to chiropractic 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 "Do - Do Not" 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 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.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office. With your written, signed authorization, we may "Click & Type" . *(fill in blank- send birthday cards, newsletters etc.)*

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.

- Required Uses and Disclosures: 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.

- You have the right to inspect and copy your protected health information. 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.

- You have the right to request a restriction of your protected health information. 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 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.

  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.

- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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.

- You may have the right to have your doctor amend your protected health information. 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.

- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. 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.

  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. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may 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 Alicia Kerins you may contact our Privacy Officer, or any staff member, including Dr. Greenfield or Dr. Cervenka at the following phone number 919-845-3280 or our website, at www.chiropractornc.com for further information about the complaint process.

This notice was published and becomes effective on November 20, 2013.