Sands Chiropractic
1701 NE 28 Street
Pompano Beach, Florida 33064

Patient Information

(Please allow our staff to photocopy your Driver's license and Insurance card)

PATIENT INFORMATION **WELCOME! PLEASE PRINT**

First Name_____ Last Name_____ M.I._____

Date of Birth____/____/____ Age_____ Gender **M F** SS#____/____/____ Marital Status **S M W D Separated**

Home Address_____

City_____ Apt_____

State_____ Zip _____

Home Phone_____ Cell Phone_____ Work Phone_____

Your Employer_____ Occupation_____

Primary surance Company_____ Subscriber's Name_____

Subscriber's Date of Birth____/____/____ Patient's Relationship to Subscriber *O* Self *O* Spouse *O* Child *O* Other

Name of Spouse, Parent or Guardian_____

Emergency Contact

Name_____ Phone_____

How did you find out about our office_____

Have you ever been to a chiropractor before *O* Yes *O* No If yes, when was your last visit_____

MY CERTIFICATION

I certify that the above information is correct

X_____ Date_____

Signature of patient or person acting on patient's behalf

MY PRIVACY

I have read a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accreditation. I may ask for and receive a copy of this notice at any time.

X_____ Date_____

MEDICAL AND HEALTH HISTORY

Patient Name_____ **Height**_____ **Weight**_____

Main Problem

What pain causes you to come to the office_____

What caused this pain_____

When did the pain start_____ How bad is the pain (circle one only) 1 = mild – 10 = Intense

1 2 3 4 5 6 7 8 9 10

How often does the pain occur (circle one) Intermittent Occasional Frequent Constant

Circle the word that best describes the pain Aching Dull Sharp Shooting Diffuse Throbbing Nagging Deep Burning Stinging Pressure

Does the pain travel to any other area_____

What makes the pain better_____

What makes the pain worse_____

Have you done anything else to treat this pain_____

Have you had similar symptoms before *O* Yes *O* No If yes, when_____

Have you had any other treatment for this condition *O* Yes *O* No If yes, when_____

Please describe the treatment and name of treating doctor_____

_____

Other History

Do you smoke *O* Yes *O* No If yes, how many per day_____

Do you drink *O* Yes *O* No If yes, how much_____

Do you exercise *O* Yes *O* No If yes, how often_____

Do you take Medication *O* Yes *O* No If yes, list type and amount taken per day

_____

_____

List Past Major Illnesses, Injuries, Surgeries, and Hospitalizations

_____

_____

_____

INITIAL EVALUATION – Automobile Accident

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Automobile Accident**

When did this accident happen? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear end ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

INITIAL EVALUATION – Automobile Accident

What inside your vehicle did you strike?

☐ Airbag	☐ Armrest	☐ Center Console	☐ Dashboard	☐ Gear shift lever/knob
☐ Headrest	☐ Rearview mirror	☐ Roof	☐ Rear window	☐ Seatback
☐ Side door	☐ Side window	☐ Wheel	☐ Windshield	
☐ Other:_____				

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Which way was your head turned during the accident?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Pain ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living

Please select all activities which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐ Dressing	☐ Reading	☐ Typing	☐ Writing	☐ Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of sexual drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling

INITIAL EVALUATION – Automobile Accident

☐ Bathing ☐ Holding

Past Medical History

Please select all conditions that you have had or are currently having:

☐ None	☐ Other	☐ Abdominal pain	☐ Weight gain/loss	☐ Angina
☐ Anorexia	☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder infection	☐ Blood disorder	☐ Breast lumps	☐ Breast soreness	☐ Bronchitis
☐ Cancer	☐ Cardiovascular Dx	☐Chest pain	☐Chronic cough	☐ Chronic sinusitis
☐ Colitis	☐ Constipation	☐ Convulsions	☐COPD	☐ Depression
☐ Dermatitis, Eczema/Rash	☐ Diabetes	☐ Difficulty in swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐Excessive thirst	☐Fainting	☐ Frequent urination
☐ General fatigue	☐ Gout	☐ Hand pain	☐ Headache	☐ Heart attack
☐ Heart disease	☐ Heartburn/Indigestion	☐ Hepatitis	☐ High Blood Pressure	☐ High cholesterol
☐ High PSA	☐ High triglycerides	☐ Hypertension	☐ Irregular menstrual flow	☐ Irritable colon
☐ Jaw pain	☐ Kidney disorders	☐ Kidney stones	☐ Liver / Gallbladder Problems	☐ Loss of appetite
☐ Loss of bladder control	☐ Low back pain	☐ Lung disease	☐ Mental Disease	☐ Mid back pain
☐ Muscular in coordination	☐Neck pain	☐ Osteoarthritis	☐ Pain in ankle or foot	☐ Pain in lower leg or knee
☐ Pain in upper arm or elbow	☐Pain in upper leg and hip	☐ Painful urination	☐ PMS	☐ Pneumonia
☐ Profuse menstrual flow	☐Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐Rheumatiod arthritis
☐Scoliosis	☐Shoulder pain	☐Stroke	☐ Swelling/stiffness joints	☐Thyroid disease of
☐Tinnitus/ ear noises	Tuberculosis	☐ Tumor	☐ Ulcer	☐ Visual disturbances
☐ Wrist pain				

INITIAL EVALUATION – Automobile Accident

Family History

Please select all conditions that run in your family:

- ☐ None
- ☐ Anorexia
- ☐ Bladder infection
- ☐ Cancer
- ☐ Colitis
- ☐ Dermatitis, Eczema/Rash
- ☐ Endometriosis
- ☐ General fatigue
- ☐ Heart disease
- ☐ High PSA
- ☐ Jaw pain
- ☐ Loss of bladder control
- ☐ Muscular coordination
- ☐ Pain in upper arm or elbow
- ☐ Profuse menstrual flow
- ☐ Scoliosis
- ☐ Tinnitus/ ear noises
- ☐ Other
- ☐ Anxiety
- ☐ Blood disorder
- ☐ Cardiovascular Dx
- ☐ Constipation
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heartburn/Indigestion
- ☐ High triglycerides
- ☐ Kidney disorders
- ☐ Low back pain
- ☐ Neck pain
- ☐ Pain in upper leg and hip
- ☐ Prostate problems
- ☐ Shoulder pain
- ☐ Tuberculosis
- ☐ Wrist pain
- ☐ Abdominal pain
- ☐ Aortic aneurysm
- ☐ Breast lumps
- ☐ Chest pain
- ☐ Convulsions
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Hand pain
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney stones
- ☐ Lung disease
- ☐ Osteoarthritis
- ☐ Painful urination
- ☐ Rapid heartbeat
- ☐ Stroke
- ☐ Tumor
- ☐ Weight Gain/loss
- ☐ Arthritis
- ☐ Breast soreness
- ☐ Chronic cough
- ☐ COPD
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ HBP
- ☐ Irregular menstrual flow
- ☐Liver/Gallbladder problems
- ☐ Mental disease
- ☐ Pain in ankle or foot
- ☐ PMS
- ☐ Renal Dx
- ☐ Swelling/stiffness of joints
- ☐ Ulcer
- ☐ Angina
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Emphysema
- ☐ Frequent urination
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Irritable colon
- ☐ Loss of appetite
- ☐ Mid back pain
- ☐ Pain in lower leg or knee
- ☐ Pneumonia
- ☐ Rheumatoid arthritis
- ☐ Thyroid disease
- ☐ Visual disturbances

INITIAL EVALUATION – Automobile Accident

Surgical History

Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies

Please select all items that you are allergic to:

☐ None	☐ Chemical	☐ Environmental	
☐ Food	☐ Medication	☐ Seasonal	☐ Other

Social History

Please answer the following

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor(s) of Sands Chiropractic and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

Assignment of Benefits

Patient/Claimant Name: _____

Policy Holder Name: _____

Claim No: _____ **Policy No:** _____

Date of Accident: _____ **Social Security No:** _____

1. I hereby instruct and direct that _____ Insurance Company pay by check monies owed for medical services rendered by **Charles T. Sands DC, or Kimberly Sands-Kahn DC**. Please make all checks payable to **Sands Chiropractic Clinic** and mail them to 1701 NE 28 Street, Pompano Beach, Fl 33064.
2. I further instruct my insurance company to cooperate with the above captioned healthcare provider in resolving all medical billing disputes. Cooperation includes, but is not limited to providing the following information:
   - **A.** Providing a pay out sheet within thirty (30) days upon request.
   - **B.** Investigating and paying all claims within thirty (30) days after receipt of billing.
   - **C.** Providing said healthcare provider with prompt and reasonable explanation in writing of the basis in the insurance policy, in relation to the facts of the case or applicable law, for denial of a claim or for the offer of a compromise settlement or payment or delay in payment past thirty (30) days from receipt of this notice.
   - **D.** Informing the healthcare provider promptly as to what additional information is necessary for the processing of this claim within thirty (30) days from the receipt of this notice.

These payment instructions are for benefits payable to me under my current insurance policy as payment toward the total charges for professional services rendered. I, as the patient, have agreed to remain personally liable to the amounts billed by the healthcare provider regardless of the amount paid by the insurance company. I further understand that said healthcare services are being provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances.

By executing this document, I am placing my insurance company on notice that **this is a direct assignment of benefits** pursuant to Florida law. As the insured or beneficiary of said insurance policy, I am assigning whatever rights I have under my policy of insurance and under Florida law to this healthcare provider. A photocopy of these instructions shall be considered as effective and valid as the original.

_____ _____

SIGNATURE OF POLICY HOLDER OR CLAIMANT **DATE**

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were actually rendered. This means that those services have already been provided.

   _____

   _____

2. I have the right and the duty to confirm that the services have already been provided.
3. I was **not** solicited by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not** solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid or **not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her own hand)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

FINANCIAL POLICY – Please read and sign below

Services are due in full at the time service is provided, unless other arrangements have been made.

Insurance Patients:
We bill many insurance carriers for you, as well as any secondary insurance. Copayments and Deductibles are due at time of service.

Medicare Patients:
We will bill Medicare and any secondary insurances for payment, and will balance bill the patient. Medicare pays 80% of the allowable charge for Spinal Manipulation only, and will limit these services based on medical necessity. Medicare does not cover any therapy, supports, supplements, x-rays, or examinations done in this office.

Workers Compensation:
If your injury is work related, we will need the claim number and insurance adjustor phone number prior to treatment. It is necessary to verify authorization before treatment is rendered.

Personal Injury/Auto:
We will bill for auto accidents or other liability or lawsuit related cases. We need to have all applicable information relative to filing an insurance claim prior to treatment. We accept Attorney liens on an individual basis, and at the Doctor's discretion.

Missed Appointments:
In fairness to the Doctor and other patients, please give as much notice as possible for any appointment you cannot make. We require 24 hours notice for any cancelled massage appointments. If proper notice for cancelled massage appointments is not given, you may be charged for the missed appointment.

Assignment of Insurance Benefits:

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **SANDS CHIROPRACTIC CLINIC.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether paid by insurance or not. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agreed to the above financial policy for payment of professional services.

Patient Signature _____ Date_____
(If patient is a minor, person with financial responsibility)

SANDS CHIROPRACTIC CLINIC
1701 N.E. 28th Street • Pompano Beach, FL 33064 • (954) 942-8402

Health Care Privacy Notice
Patient's Rights

Name of Doctor or Clinic: Sands Chiropractic

Compliance Officer: K Sands

Our staff is committed to maintaining the privacy of your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this health care privacy notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this notice at anytime without additional notice to you except to publicly post in our office and/or make available to patients any updated notices. Photocopy of this notice is available to you upon request.

Use and Disclosure of PHI

Our office use and disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list of situations in which your PHI can be dissolved without your written authorization.

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgement from you is not practical until after the emergency situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations.

Health Care Operations: For certain administrative, financial, legal and quality control activities that are necessary to run its business and support the core functions of treatment and payment.

Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purposes.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other party to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions.

Public Health Purposes: Your PHI may be disclosed to legally authorized public health authorities for the purpose of the prevention, control, investigation, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.

SANDS CHIROPRACTIC CLINIC
1701 N.E. 28th Street • Pompano Beach, FL 33064 • (954) 942-8402

Treatment: For the coordination or management of your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.

Workers Compensation: State laws may permit disclosure of your PHI to comply with workers' compensation laws without your authorization and no minimum necessary standard is required.

Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to review and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to your or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by state law.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed, or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

Your may revoke authorization, in writing, at any time, except in the event that the doctor has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Office if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed with 180 days of when you knew or should have known that the violation occurred. You may also contact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy law prohibits our office from taking any retaliatory actions against anyone who files a complaint.