

- **Whom may we thank for referring you to PANGEA ? \_\_\_\_\_**

## APPLICATION FOR CARE AT PANGEA CHIROPRACTIC

Today's Date: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Are you Pregnant  Yes  No If yes, due date: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Children Names and ages: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*Please check box if you don't want text reminders  No \*Are you an active or military veteran?  Yes  No

### HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: **Primary:** \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **1** to **10** with **10 being the worst pain** and **zero being no pain**, rate your above complaints by **circling the number**:

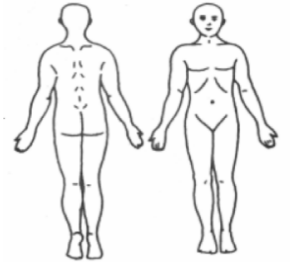
**Primary** or chief complaint PAIN/DISCOMFORT LEVEL:

- |                                     |  |
|-------------------------------------|--|
| <input type="radio"/> Right now:    | 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 |
| <input type="radio"/> On average:   | 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 |
| <input type="radio"/> At its best:  | 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 |
| <input type="radio"/> At its worst: | 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 |

**Second** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:



**R = Radiate B = Burning D=Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingle O=Other**

When did the primary problem begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition has been treated by anyone in the past?  No  Yes **If yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_  N/A

What **relieves** your symptoms? \_\_\_\_\_

What makes your symptoms feel **worse**? \_\_\_\_\_

### LIST RESTRICTED ACTIVITY:

1) \_\_\_\_\_

3) \_\_\_\_\_

2) \_\_\_\_\_

4) \_\_\_\_\_

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_  
\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state what type of treatment: \_\_\_\_\_

**Who provided it:** \_\_\_\_\_ **How long ago?** \_\_\_\_\_ What were the results.  Favorable  Unfavorable please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

Have you been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past** or **C** for **Currently**:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Vascular Disease

Other serious conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

INJURIES
SURGERIES
MEDICATIONS
DISEASES

**SOCIAL HISTORY**

**1. Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never

**2. Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never

**3. Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**4. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

**FAMILY HISTORY:**

**1.** Does anyone in your family suffer with the same condition(s)?  No  Yes

**If yes whom:**  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)

Have they ever been treated for their condition?  No  Yes  I don't know

**2. Any** other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to Pangea Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Pangea Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

**PANGEA CHIROPRACTIC**  
**Automobile/PI Accident or Work Comp Questionnaire**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
HR#:

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Please answer all questions completely.

Please explain in detail how your accident happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

List the extent of your injuries as you know them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check symptoms you have noticed since the accident:

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Depression   | <input type="checkbox"/> Fatigue         |
| <input type="checkbox"/> Light Bothers Eyes       | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Head Seems to Heavy      | <input type="checkbox"/> Memory Loss     | <input type="checkbox"/> Feet Cold    | <input type="checkbox"/> Neck Stiff      |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring       | <input type="checkbox"/> Hands Cold   | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Tension      | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Irritability    |
| <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Cold Sweats     |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Stomach Upset   |                                       |  |

Symptoms other than above: \_\_\_\_\_

\_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Hospitalized?  Yes  No If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Name of Doctor(s): \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

If so, what was the doctor's name? \_\_\_\_\_ D.C., M.D., D.O., D.D.S.

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms ...  Improving?  Getting worse?  Same?

Driver of other vehicle (if any):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Claim No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Claim No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his/her name and address \_\_\_\_\_

You were heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Other vehicle was heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

You were struck from Behind/ Front/ Left Side/ Right Side \_\_\_\_\_

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Doctor Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

## ACTIVITIES OF LIFE

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please mark **P** for in the Past or **C** for Currently have:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Headache                  | <input type="checkbox"/> Sinus/Drainage problems   | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Neck pain                 | <input type="checkbox"/> Swollen/Painful joints    | <input type="checkbox"/> Menopausal problems   |
| <input type="checkbox"/> Jaw pain, TMJ             | <input type="checkbox"/> Skin problems             | <input type="checkbox"/> Menstrual problems    |
| <input type="checkbox"/> Shoulder pain             | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> PMS                   |
| <input type="checkbox"/> Upper back pain           | <input type="checkbox"/> Loss of balance           | <input type="checkbox"/> Bedwetting            |
| <input type="checkbox"/> Mid back pain             | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Learning disability   |
| <input type="checkbox"/> Low back pain             | <input type="checkbox"/> Double vision             | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Hip pain                  | <input type="checkbox"/> Blurred vision            | <input type="checkbox"/> Heartburn             |
| <input type="checkbox"/> Back curvature            | <input type="checkbox"/> Ringing in ears           | <input type="checkbox"/> Heart problems        |
| <input type="checkbox"/> Scoliosis                 | <input type="checkbox"/> Hearing loss              | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Numb/Tingling arms, hands | <input type="checkbox"/> Depression                | <input type="checkbox"/> Low blood pressure    |
| <input type="checkbox"/> Numb/Tingling legs, feet  | <input type="checkbox"/> Irritable                 | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Pregnant (now)            | <input type="checkbox"/> Mood changes              | <input type="checkbox"/> Difficulty breathing  |
| <input type="checkbox"/> Frequent colds/flu        | <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> Lung problems         |
| <input type="checkbox"/> Convulsions / Epilepsy    | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Kidney problems       |
| <input type="checkbox"/> Tremors                   | <input type="checkbox"/> Prostate problems         | <input type="checkbox"/> Gallbladder problems  |
| <input type="checkbox"/> Chest pain                | <input type="checkbox"/> Impotence/Sexual Dysfunc. | <input type="checkbox"/> Liver problems        |
| <input type="checkbox"/> Pain with cough/sneeze    | <input type="checkbox"/> Digestive Problems        | <input type="checkbox"/> Hepatitis (A/B/C)     |
| <input type="checkbox"/> Foot or Knee problems     | <input type="checkbox"/> Colon Trouble             | <input type="checkbox"/> Eating disorder       |
|  |  | <input type="checkbox"/> Trouble sleeping      |

Other symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Pangea Chiropractic

## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, 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.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students 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 physician. We may also call you by name in the waiting room when your physician 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 may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization. Your Rights. Following is a statement of your rights with respect to your protected health information.



You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled 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.

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 your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician 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. You then have the right use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

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

You have the right to receive an accounting of certain disclosures we have made, if any, of protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to 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 contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before January 1<sup>st</sup> 2014

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our FHPAA Compliance Officer in person or by phone at our Main Phone Number

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

**Print Name:** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_