

# PATIENT PERSONAL/CONFIDENTIAL DATA

Pt. No. \_\_\_\_\_ QN No. \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

How did you learn about this office? \_\_\_\_\_

Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Wk) \_\_\_\_\_ X \_\_\_\_\_

## PRIMARY INSURANCE

Name of Co.: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured is:  Patient  Spouse  Other

## SECONDARY INSURANCE (Medicare patients only)

Name of Co.: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured is:  Patient  Spouse  Other

Purpose of this appointment. Please list your complaints: \_\_\_\_\_

Condition began: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_

Was condition caused by an accident?  Auto  On the Job  Other \_\_\_\_\_

Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_

Other doctor/doctors seen for this condition: \_\_\_\_\_

Have you been treated by a doctor for any health condition in the last year?  Yes  No

If yes, please describe: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Parent's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING.

Patient: \_\_\_\_\_ No.: \_\_\_\_\_ Date: \_\_\_\_\_

**MUSCULO SKELETAL SYSTEM**

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine
- FEMALE**
- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Weight trouble
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems

**CARDIO-VASCULAR RESPIRATORY**

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Varicose veins
- Heart problems
- Lung problems

**NERVOUS SYSTEM**

- Insomnia
- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

**EYE, EAR, NOSE AND THROAT**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult with speech
- Sinus
- Allergy
- Jaw pain

**HABITS**

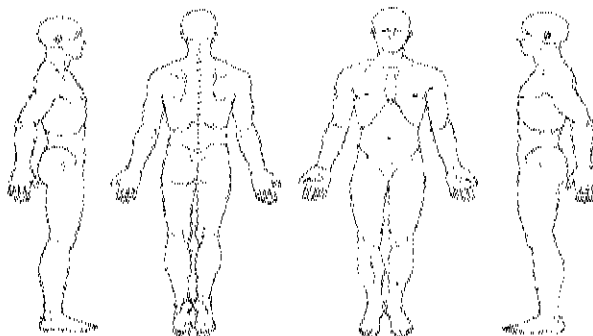
- Drug abuse
- Cigarettes
- Alcohol abuse
- Coffee or Tea
- Exercise

**ARE YOU PREGNANT?**  
 YES  NO

**PLEASE CHECK ANY LISTED BELOW THAT APPLY TO YOU**

- Contraceptive devices
- Recent surgery using clips or staples
- Metal fragments in any part of your body
- Prostheses
- Pacemaker
- Any form of implants
- Spinal fusions
- Contact lenses
- Body piercings

**SYMPTOM LOCALIZATION**



P - Pain      N - Numb      S - Spasm  
 T - Tenderness      H - Hypoesthesia (Tingling)

**Pain Index (Circle one)**

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

**LONGACRE CHIROPRACTIC CENTER**

Michel F. Longacre, D.C.  
487 Crockett Drive • Lewisville, Texas 75057  
(469) 549-1810 • Fax: (972) 436-6068

**OFFICE POLICY**

**ADDENDUM**

Some insurance companies have recently begun to determine that some charges (including manipulations) are not "medically necessary". They have done this in spite of the fact that benefits were correctly verified and even after payment has been issued on these same services for prior dates of service. Therefore, we have found it necessary to add the following statement to our Office Policy. Please be aware that should this happen, you will be charged the current cash patient rate for these charges, and we will work with you any way that we can.

"Should my insurance company determine that any treatment I receive at this office is not medically necessary or not covered by my policy and states in writing that the member is not responsible for this charge unless they agreed to be responsible for the charge in writing before the service or supply was given, I hereby agree to be financially responsible for those charges."

Please sign and date below acknowledging that you have read, understand, and agree with the policies stated above.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Michel F. Longacre, D.C.**  
487 Crockett Drive + Lewisville, Texas 75057  
(469) 549-1810 + Fax: (972) 436-6068

## OFFICE POLICY

Welcome to the office of Michel F. Longacre, D.C.. We appreciate the confidence you have shown by allowing us to be involved with your healthcare. It is our goal to do everything possible to make your care here as trouble-free as possible.

Because everyone prefers to "know the rules" in the beginning, we have attempted to set forth guidelines in regard to payment procedures. If you have questions at any time in regard to your account, please do not hesitate to ask.

1. Payment in full is required at the time services are rendered unless other arrangements are made.
2. There is a \$25.00 returned check fee.
3. Copies of medical records require an advanced notice of 3-5 business days and pre-payment of \$30.00 minimum.  
**Note:** These are usually requested by the insurance company and/or attorneys, and they are usually the ones to pay for these services.

Additional forms required from your insurance company (i.e. disability reports, questionnaires, etc.) will be charged as follows:

1<sup>st</sup> form: Free

Any additional forms: Up to \$30.00 per form. Pre- payment is required.

In regard to the completion of additional forms and requests for medical records by other entities not directly related to the coordination of care or the reimbursement for services rendered by this office:

1<sup>st</sup> form: Free

Any additional forms: Up to \$30.00 per form. Pre- payment is required.

4. No refunds on credit balances are issued until all treatments are completed, and the patient has been released from care unless other arrangements are made with the back office.
5. Any change in address, phone numbers, employment, and/or insurance needs to be given to the front desk so that our records may be kept current. It is the patient's responsibility to notify us of any changes, and the patient agrees to be responsible for any balances that may occur due to these changes.

## PATIENT TYPE

### CASH:

Patients who do not have insurance coverage or who cannot provide us with complete insurance information will be considered cash patients. Payment is expected in full every visit, unless prior arrangements are made.

### INSURANCE:

All patients having insurance coverage will be expected to pay their co-payment every visit. Payment for any item or deductible that insurance does not cover will also be expected at that time. Please remember that the insurance contract is between the insured and his/her insurance company. If payment has not been received from the insurance company within 60 days, the patient will be responsible for the unpaid balance and will be given any necessary paperwork for him/her to obtain reimbursement from the insurance company.

### PERSONAL INJURY:

Personal injury cases are handled in the following manner.

- We will file claims to the patient's PIP auto insurance.
- Once the PIP benefits have been exhausted, we will file claims to the patient's major medical insurance.

or

- The patient will pay cash and seek any reimbursement available from the insurance company/companies.

**Please be advised that we will not accept third party cases or Letters of Protection from attorneys (LOP's), nor will we "cut our bill" or negotiate the balance under any circumstances.**

**WORKMAN'S COMPENSATION:**

Effective March 01, 2005, we no longer except Worker's Compensation cases. If you feel your injury may be work-related in any way, please let us know so that we may refer accordingly.

**MEDICARE:**

We accept Medicare assignment and are a participating provider. Government policy requires all offices to file claims for any services rendered to a Medicare patient. The services covered by Medicare and the supplementary insurance benefits vary. Our insurance department will be happy to verify coverage and discuss specific information.

**ALL FINANCIAL ARRANGEMENTS MUST BE MADE THROUGH THE BILLING OFFICE!**

I understand, agree and acknowledge that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

I do understand that the above referenced office will release my Protected Health Information to insurance carriers and other health care providers for the purpose of treatment, payment and/or health care operations. This document shall act as my written authorization for this act of disclosure of my Protected Health Information. Without written authorization, information may be disclosed according to Texas Law that overrides HIPPA rules regarding: child abuse, neglect, domestic violence, or other accidents under Texas law, workers compensation cases, or an emergency.

I further authorize Michel F. Longacre, D.C. his authorized agents and employees to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said office of Michel F. Longacre, D.C., which checks, drafts or money orders are issued to pay for chiropractic services or the like which have been performed by Michel F. Longacre, D.C. at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Please sign and date below acknowledging that you have read, understand, and agree with the policies stated above.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Rev 01/05/09

# INFORMED CONSENT

## DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

### CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic healthcare seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

### ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. *Due to the complexities of nature, no doctor can promise you specific results.* This depends upon the inherent recuperative powers of the body.

### DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS, and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### INFORMED CONSENT FOR CHIROPRACTIC CARE

In coming to the doctor of chiropractic, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or healthcare if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through healthcare procedures the condition from which he is suffering: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

### RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answer to all problems. Both have made great strides in alleviating pain and controlling disease.

I have read and understand the foregoing. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I further authorize him to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the office, the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

MICHEL F. LONGACRE, D.C., 487 CROCKETT DRIVE, LEWISVILLE, TX 75057

**ASSIGNMENT AND INSTRUCTIONS FOR  
DIRECT PAYMENT TO DOCTOR**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Employer: \_\_\_\_\_  
Claim or Group #: \_\_\_\_\_ SS# or ID#: \_\_\_\_\_

I hereby instruct the above named Insurance Company to pay by check made payable and mailed directly to:

**Michel F. Longacre, D.C.  
487 Crockett Dr.  
Lewisville, TX 75057**

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

**Michel F. Longacre, D.C.  
487 Crockett Dr.  
Lewisville, TX 75057**

for professional or medical and expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I fully acknowledge that Dr. Longacre will not "cut" nor negotiate my bill neither at my request nor the request of any person speaking on my behalf.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. **I specifically authorize the insurance company through which I have PIP coverage to divulge the amount of my PIP coverage to Dr. Longacre and/or his staff.**

I further authorize Michel F. Longacre, D.C. and his authorized agents and employees to endorse any and all check, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said offices of Michel F. Longacre, D.C., which checks, drafts or money orders are issued as payment for chiropractic services or the like which have been performed by the office of Michel F. Longacre, D.C. at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

This is my PIP insurance (Personal Injury Protection through my auto insurance)?  YES  NO  
This is my only medical insurance?  YES  NO  
This is my primary insurance but I also have a secondary insurance?  YES  NO  
Name of Secondary Insurance? \_\_\_\_\_

Dated at \_\_\_\_\_ County, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

**MICHEL F. LONGACRE, D.C.**  
**Longacre Chiropractic Center**  
**487 Crockett Drive**  
**Lewisville, Texas 75057**  
**(469) 549-1810**  
**(972) 436-6068 Fax**

Effective date of notice: April 14, 2003  
(Privacy Officer: Dee Amason)

**NOTICE OF PRIVACY PRACTICES**

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; treatments by Dr. Longacre; referring you to another doctor or clinic for care; obtaining authorization for care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

**Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your chiropractic care (i.e. scheduling appointments or making payments on your account).**

## **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photo copies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons whom we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

## **PATIENT ACKNOWLEDGEMENT**

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date