The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

Thank you for choosing us as your chiropractor. We realize that you have many choices for chiropractic care and are delighted that you have chosen us to provide those services. Please be assured that our staff is highly qualified and well trained to provide your care.

Please read each numbered section. Any of our staff will answer any question you may have about this information.

1. Please read and fill out all the attached paper work and return to our office. It is 5 Pages. (Page 1:Intake information, Page 2,3, &4 Your Medical History, and Page 5 Assignment of Benefits so we can bill your insurance.)
2. **The four-page privacy brochure is yours to keep.** This outlines your medical rights.
3. If you were referred here from a physician, we will be contacting him/her, with your approval, of your progress. Please inform us of your next scheduled appointment with your Doctor.
4. **Appointments:** Please be courteous of your fellow patients by arriving promptly for your appointments. If you are late you may have to wait, as others who arrive on time will be seen first. If you find that you can not be on time, please give us a call, as we may make arrangements to our schedule. If your are unable to keep an appointment due to illness or other conflict, please notify us at least 24 hours in advance. We can then reschedule your appointment for another time. We want to keep your schedule appointment time. However, please bear in mind that priority scheduling will be given to those patients that are emergency cases. Also some times treating a patient may take slightly longer that expected. In these situations you may have to wait. We are certain that you can understand this and your cooperation and flexibility are greatly appreciated.
5. In case of bad weather, please call the office to confirm your appointment.
6. **You will need to follow the schedule out lined by the doctor to achieve your treatment goals. Repeated cancellations/missed appointments may result in being discharged from care**.
7. If you are hospitalized or suffer a change in your medical status you must report this to the doctor.
8. **If you have a change in insurance it is your responsibility to inform our staff. If you fail to notify the office of any changes in your insurance you will be held responsible for any charges for services rendered.**

We hope you will be please with our care and refer your family and friends to us. If you have a concern about your care or treatment that you receive at our clinic, please speak to the doctor. Thank you again for choosing us and we look forward to serving you.

X_____ _____

Patient's (or Guardian's) Site

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

In order to serve you properly, we will need the following information. Please print clearly. All information will be confidential. PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD, FRONT AND BACK, AND ANY ADDITIONAL INSURANCE INFORMATION MAY HAVE.

Date:_____ Patients name:_____ _____ _____
First MI Last

Address:_____
Street City State ZIP

Home phone:_____ Cell: _____ Work: _____

Email Adress_____ Birthdate:_____

SSN:_____ Sex_____ # of Children/Ages_____

Employed by:_____ Type of work:_____

Martial Status: M S W D Family Physician_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE. I acknowledge that I have been given the chance to review and receive a copy, if so desired, of the Privacy Notice.

Insurance Information: Is the Patient the primary insured? ☐ Yes ☐ NO

Insured/ Spouse's/ Parent's name:_____ _____ _____
First MI Last

Address:_____
Street City State ZIP

Home phone:_____ Cell: _____ Work: _____

SSN:_____ ☐ Male ☐ Female Birthdate:_____

Insured/ Spouse's/ Parent's employer:_____

Work Address:_____
Street City State ZIP

Emergency Contact:_____ Phone:_____

I understand that it is my choice that I treat with Chris Bowe D.C.. I also understand that I am personally responsible for all charges for services rendered to me, or my child, in connection with this matter. I will make payment myself within a reasonable period of time after treatment has been completed. If my account is placed in collections I understand that I am responsible for attorney fee, collections and court costs. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I assign to Chris Bowe DC any and all rights and benefits under any insurance contracts, for payments of claims rendered by the doctor. I also hereby authorize the doctor to file insurance claims on my behalf and direct all payments of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Patient's (or Guardian's) Site

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

In order to serve you properly, we will need the following information. **Please print clearly**. All information will be confidential.

Name:_____ Date:_____
Why are we seeing you?:_____
_____
Date of onset?_____ Causes(If Known)_____
What improves your pain?_____
What worsens your pain?_____
Are your Symptoms getting worse? Yes / No Are they: Constant / Intermitent
Does the Pain wake you from Sleep_____
Does sneezing, coughing or defecation ever increase you pain?_____
Is it interfering with your : ☐ Sleep ☐ Work ☐ Sports ☐ Daily Routine ☐ Personal habits
Other_____
Doctors Seen for this condition: _____Date last Seen_____
Their Diagnosis _____ Their Treatment_____
Results of their treatment_____

Previous Chiropractic Care: ☐ Yes ☐ No Date last seen_____
For what condition:_____
LIST ANY ACIDENTS (Please List Type And Date Including Auto Accidents)_____
_____
List all Traumas, Fractures, Broken Bones:_____
Have You Ever Been X-Rayed? ☐ Yes ☐ No Ever have an MRI, CAT SCAN ECT.) ☐ Yes ☐ No
Ever Had A Spinal Injection or Spinal Tap? ☐ Yes ☐ No Ever On Crutches? ☐ No ☐ Yes
Are You Presently Taking Any Medication-Prescription Or Over-The-Counter?
☐ **Yes** ☐ **No If So, What Drugs?**_____
List past medication which were used on a regular basis._____
List all Vits, Herbs, Supplements Ect:_____
Last Dr's visit_____ Any Abnormalities_____
Have you had or have physiological or emotional problems?_____

OPERATIONS AND PROCEDURES (Please write the date(s) of any procedure you have had.)
Tonsillectomy Date_____Gall Bladder Date_____ Back Operations Date_____
Tubes in Ears Date_____Appendectomy Date_____ Female Organs Date_____
Rectal Surgery Date_____Sinus Date_____ Hernia Date_____
Thyroid Date_____Stomach Date_____
Other _____

I hereby authorize the Doctor to treat my condition, as he deems appropriate through the use of manipulation throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor or any medical diagnosis.

Patient/Guardian's Signature_____ Date_____

X_____ _____
Patient's (or Guardian's) Site

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

Name: _____ Date: _____

PLEASE NOTE THAT THIS IS A CONFIDENTIAL HEALTH QUESTIONNAIRE.
PLEASE CHECK THE APPROPRIATE BOX.

PAST REFERS TO ANY CONDITION OR SYMPTOM YOU HAD EXPERIENCED 6 MONTHS AGO OR PRIOR. **PRESENT/ CURRENT** REFERS TO ANY CONDITION OR SYMPTOM WHICH YOU NOW HAVE, OR HAVE HAD IN THE PAST 6 MONTHS, OR KNOW TO BE A REOCCURRING CONDITION. LEAVE ANY QUESTIONS BLANK SHOULD SUCH A QUESTION NOT PERTAIN TO YOU.

PAST	PRESENT	GENERAL
☐	☐	FATIGUE
☐	☐	FEVER
☐	☐	SWEATS
☐	☐	RECURRING INFECTIONS
☐	☐	SWOLLEN BODY PART
☐	☐	CANCER/TUMORS
☐	☐	DIABETES
☐	☐	ANEMIA
☐	☐	HEART DISEASE
☐	☐	STROKE
☐	☐	UNEXPLAINED WEIGHT LOSS
☐	☐	SIGNIFICANT INFECTIONS
		NEUROLOGY
☐	☐	HEADACHES
☐	☐	MIGRAINES
☐	☐	LOSS OF CONSCIOUSNESS
☐	☐	STROKE
☐	☐	FAINTING
☐	☐	NUMBNESS (Please list where)
		_____
☐	☐	MUSCLE WEAKNESS
☐	☐	SEIZURES/EPILEPSY
☐	☐	CONVULSIONS
☐	☐	TREMORS
☐	☐	BOWEL/BLADDER DYSFUNCTION
☐	☐	DIZZINESS
☐	☐	BALANCE PROBLEMS
☐	☐	CHANGE IN PERSONALITY
☐	☐	MULTIPLE SCLEROSIS
☐	☐	MUSCLE DISEASE
☐	☐	POLIO
☐	☐	SLIPPED DISC/HERNIATION
☐	☐	PINCHED NERVE
☐	☐	CARPAL TUNNEL SYNDROME
☐	☐	HEAD TRAUMA/CONCUSSION
☐	☐	BEEN KNOCKED UNCONSCIOUS
☐	☐	VERTIGO
☐	☐	OTHER (Please list)
		MUSCLE AND JOINTS
☐	☐	ARTHRITIS
☐	☐	BURSITIS
☐	☐	LOW BACK PAIN
☐	☐	NECK PAIN
☐	☐	MIDBACK PAIN
☐	☐	ANY JOINT PAIN (Please list)
		_____
☐	☐	AUTOIMMUNE (ie LUPUS)
☐	☐	GOUT

PAST	PRESENT	MUSCLE AND JOINTS (CONTINUED)
☐	☐	POOR POSTURE
☐	☐	SCOLIOSIS
☐	☐	SWOLLEN JOINTS
☐	☐	PODIATRIC/FOOT PROBLEMS
☐	☐	RHEUMATISM
☐	☐	LYME
☐	☐	OTHER (Please list)
		GENITOURINARY
☐	☐	FREQUENT URINATION
☐	☐	INABILITY TO CONTROL KIDNEYS
☐	☐	KIDNEY STONES
☐	☐	URINARY TRACT INFECTION
☐	☐	BLOOD IN URINE/CHANGE IN COLOR
☐	☐	PAINFUL URINATION
☐	☐	OTHER (Please list)
		CARDIOVASCULAR
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	LOW BLOOD PRESSURE
☐	☐	CHEST PAIN/PRESSURE
☐	☐	ANGINA
☐	☐	IRREGULAR HEART BEAT
☐	☐	HEART ATTACK
☐	☐	ABNORMAL EKG TESTS
☐	☐	ABNORMAL CARDIAC TESTS
☐	☐	HARDENING OF THE ARTERIES
☐	☐	BLOOD CLOTS
☐	☐	HEART MURMUR
☐	☐	POOR CIRCULATION
☐	☐	VARICOSE VEINS
☐	☐	OTHER (Please list)
		RESPIRATORY
☐	☐	ASTHMA
☐	☐	WHEEZING
☐	☐	SHORTNESS OF BREATH
☐	☐	EMPHYSEMA
☐	☐	PLEURISY
☐	☐	CHEST PAIN
☐	☐	PNEUMONIA
☐	☐	CHRONIC COUGH
☐	☐	TUBERCULOSIS
☐	☐	SPITTING UP BLOOD
☐	☐	PRODUCING PHLEGM
☐	☐	REOCCURRING COLDS
☐	☐	SLEEP APNEA
☐	☐	SNORING
☐	☐	OTHER (Please list)

X_____ _____

Patient's (or Guardian's) Site

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

Name: _____ Date: _____

PAST	PRESENT	GASTRO INTESTINAL
☐	☐	COLITIS
☐	☐	IRRITABLE BOWEL SYNDROME
☐	☐	HEART BURN/REFLUX
☐	☐	ULCERS
☐	☐	BLOODY STOOLS
☐	☐	BLACK STOOL
☐	☐	CONSTIPATION
☐	☐	REOCCURRING DIARRHEA
☐	☐	GALL BLADDER PROBLEMS
☐	☐	HEMORRHOIDS
☐	☐	HEPATITIS
☐	☐	CHIRROSIS/LIVER DISEASE
☐	☐	JAUNDICE
☐	☐	NAUSEA
☐	☐	VOMITING
☐	☐	VOMITING BLOOD
☐	☐	APPENDICITIS
☐	☐	OTHER (Please list)

SKIN

☐	☐	ITCHING
☐	☐	RASHES
☐	☐	ECZEMA
☐	☐	PSORIASIS
☐	☐	CHANGE IN SKIN COLOR
☐	☐	CHANGE IN MOLES
☐	☐	TOO DRY/OILY
☐	☐	COLD SORES
		DATE OF LAST VISIT TO DERMATOLGIST
		_____
☐	☐	OTHER (Please list)

ALLERGY

☐	☐	ENVIRONMENT
☐	☐	FOODS (please list)
☐	☐	DRUGS (please list)

EYES, EARS, NOSE AND THROAT

☐	☐	DEAFNESS/LOSS OF HEARING
☐	☐	TINNITUS/RINGING EARS
☐	☐	ENLARGED THYROID/GOITER
☐	☐	EYE PAIN
☐	☐	CHANGE IN ABILITY TO SEE
☐	☐	GLAUCOMA
☐	☐	GUM TROUBLE
☐	☐	HOARSENESS
☐	☐	NASEL OBSTRUCTION
☐	☐	HORMONE (ENDOCRINE) ABNORMALITIES

PAST	PRESENT	EYES, EARS, NOSE, THROAT CONTIUED
☐	☐	WEARS GLASSES
☐	☐	NOSEBLEEDS
☐	☐	SINUS PROBLEMS
☐	☐	SORE THROAT
☐	☐	TONSILLITIS
☐	☐	DIFFICULTY SWALLOWING
☐	☐	DATE OF LAST VISIT TO DENTIST
		_____
☐	☐	OTHER (Please list)

☐ **FOR MEN**

☐	☐	PROSTATE PROBLEM
☐	☐	INABILITY TO COMPLETELY URINATE
☐	☐	DISCHARGE FROM PENIS
☐	☐	LUMPS/BUMPS ON TESTICLES
☐	☐	HIV/AIDS
☐	☐	SEXUALLY TRANSMITTED DISEASE
☐	☐	OTHER (Please list)

☐ **FOR WOMEN**

☐	☐	EXCESSIVE MENSTRUAL FLOW
☐	☐	VAGINAL DISCHARGE
☐	☐	IRREGULAR CYCLE
☐	☐	MISCARRIAGE
☐	☐	FIBROCYSTIC BREAST
☐	☐	LUMPS/BUMPS ON BREAST
☐	☐	HOT FLASHES
☐	☐	MENOPAUSAL SYMPTOMS
☐	☐	HIV/AIDS
☐	☐	SEXUALLY TRANSMITTED DISEASE
		DATE OF LAST MENSTRUAL CYCLE
		_____
☐	☐	ARE YOU PREGNANT? YES / NO
☐	☐	OTHER (please list)

PERSONAL HABITS

COFFEE/TEA/CAFFEINE AMOUNT
OF CUPS A DAY _____
ALCOHOL AMOUNT
OF DRINKS A DAY _____

☐	☐	ALCOHOLISM
☐	☐	SUBSTANCE USE
☐	☐	TOBACCO USE

OF PACKS A DAY _____
OF YEARS _____

GOOD	AVG	POOR	
☐	☐	☐	SLEEP
☐	☐	☐	APPETITE
☐	☐	☐	EXERCISE

ARE THERE ANY HEALTH CONDITIONS YOU FEEL ARE IMPORTANT THAT WE DID NOT ASK YOU ABOUT?

_____

FAMILY HEALTH INFORMATION (Please list below any known health problems with any family members)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

X_____ _____

Patient's (or Guardian's) Site

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

INSURANCE INFORMATION, FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

DUE TO INDICIDUAL TYPES OF INSURANCE POLICIES, YOUR INSURANCE POLICY MAY OR MAY NOT COVER ALL OR PART OF THE CARE PROVIDED TO YOU I N THIS OFFICE. It is my responsibility to know my specific insurance benefits.

I assign to Chris Bowe DBA as The Chiro Express , any and all rights and benefits under any insurance contracts, for payment of claims rendered to me by The Chiro Express. I authorize Chris Bowe DBA as The Chiro Express to file insurance claims on my behalf for services rendered to me by said group. File and proceed with any appeals process and or arbitration directed toward my insurance carrier should my insurance company deny payment of claim. I authorize all information regarding benefits under any insurance policy to my claims by The Chiro Express to be released to any representative of The Chiro Express.

I direct that all payments for services rendered to me by The Chiro Express be made directly to The Chiro Express. Should my insurance carrier provide payment to myself instead of the physician, such payment shall immediately be provided to my physician by myself for the same amount.

I understand that I am financially responsible for all charges whether or not they are covered by the insurance (ie. Deductibles, co-insurance, co-payment, or non covered services deemed necessary by my physician) If my account is placed in collections, I understand that I am responsible for attorney fees, collections, and court costs.

This authorization shall remain valid until written notice is given by me revoking said authorization. I permit a copy of this authorization to be used in place of the original. I understand the nature and effect of this assignments of benefits contract.

Patients Name Printed: _____ Date_____

Patient's (or Guardian's) Signature_____

AUTHORIZATION TO TREAT A MINOR

I hereby authorize The Chiro Express and whomever they may designate as it's assistant, or employee, to examie and or treat my child.

Childs Name _____ Date _____

Parent or guardian signature _____

The Chiro Express

Phone 347-429-6998 Fax 347-240-9799

Notice of Privacy Practice
The Chiro Express

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 Contact who is Lenise R. Graddy

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required 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. Upon your request, we will provide you with any revised Notice of Privacy Practices by, 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your physician will use or disclose your protected health information as described in this Section 1. 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. 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 a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. 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.

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 physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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 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, marketing and fundraising activities, 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 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 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 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 may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon 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. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's 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 Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. 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 physician may, using professional judgement, 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.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. ***[This section will only be applicable to larger practices or those practices that operate facilities.]***

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, general condition or death. 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.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

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.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

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 (1) legal processes 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.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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.

2. 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 physician 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 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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact 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 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. If your physician 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 physician. You may request a restriction by placing it in writing to the practice's privacy officer.

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 to our Privacy Contact.

You may have the right to have your physician 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 Contact to determine 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, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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.

3. 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.

You may contact our Privacy Officer, **Lenise R. Graddy**:

- (347)429-6998
- thechiroexpress@gmail.com

for further information about the complaint process.

This notice was published and becomes effective on **April 14, 2005**