WELCOME TO ALPINE CHIROPRACTIC CENTER, PC.

Patient Information

Patient's First Name	Initial	Last Name	Date of Birth	Gender
			/ /	❑ Male ❑ Female

Mailing Address	City	State	Zip Code

Home phone	Work phone	Cell phone
( ) -	( ) -	( ) -

Employer	Occupation	Email address

Marital Status	Pregnancy statement (for female patients)
❑ Single ❑ Married ❑ Other	❑ I **am** pregnant. ❑ I **am not** pregnant, nor is pregnancy suspected at this time. ❑ I am **not sure**.

Emergency contact name	Emergency contact phone

Medical Information

Primary care physician	Name of practice

Please describe your general symptoms:	Are your symptoms a result of: ❑ Work injury, Date: ____/____/_____ ❑ Car accident, Date: ____/____/_____ ❑ Other injury or accident, Date: ____/____/_____
Other practitioners who have treated this condition:	How did you hear about us?

Insurance Information

Name of insured	Relationship to patient	Insured's date of birth
		/ /

Financial responsibility: I clearly understand and agree that I am personally responsible for payment in full for all services rendered to me with associated fees whether or not they are covered by insurance. I agree that I am responsible for obtaining coverage information directly from my insurance company, and I acknowledge that Alpine Chiropractic Center PC is not responsible for collecting or communicating this information to me. If as a courtesy, this information is discussed with me, Alpine Chiropractic Center PC and its associates shall not be held liable for the accuracy or completeness of the information.

INSURANCE BILLING: I understand that Alpine Chiropractic Center, PC. will bill my insurance company as a courtesy upon presentation of a current insurance card, and I authorize the release of any information necessary to assist me in making collection from the insurance company. I permit Alpine Chiropractic Center, PC. to credit my account with amounts paid upon receipt and to endorse co-issued remittances for the conveyance of credit to my account. I UNDERSTAND THAT ALL BILLS ARE ULTIMATELY MY RESPONSIBILITY.

LIENS: I understand that Alpine Chiropractic Center may employ the use of a lien as part of their collection practices. I agree that I am fully responsible for balances not covered by lien payments and guarantee payment of my bill in full regardless of lien law limitations.

CANCELLATION FEE: I agree to pay a $50.00 cancellation fee for a massage appointment no-show or a massage appointment cancelled less than 24 hours in advance. This fee is not covered by any insurer and is the patient's responsibility.

REBILLING FEE: I agree to pay a $10 per month statement fee for any unpaid patient balances (i.e. co-payments, deductibles, and other amounts not covered by insurance) that are billed to me more than once.

Consent for treatment: I hereby authorize the doctors at Alpine Chiropractic Center, PC. and whomever they may designate as their assistants to administer x-rays, chiropractic adjustments, other chiropractic procedures, various modes of physical therapy, and massage, as they so deem necessary.

Privacy: 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. To ensure your privacy, Alpine Chiropractic Center, PC, does not conduct any electronic business transactions. You have a right to view or receive a copy of the information in your medical chart. This information is not disclosed to any other party without your written permission or court documents legally requiring this. From time to time, you may hear patient information within our offices; we ask that you keep it confidential.

I certify that I have read and understood the information above, and that what I have written is true and correct.

Signature of Patient _____ Date _____ Parent/guardian signature (if patient is under 18) _____ Date _____

MOTOR VEHICLE ACCIDENT HISTORY FORM

Your name:_____ Today's date:_____

Address:_____

Home phone #:_____ Work phone #:_____

Sex:_____ Date of birth:_____ Height:_____ Weight:_____

Social Security #:_____ Accident claim #:_____

Your auto Insurance CO:_____ Policy #:_____

Driver's Insurance CO:_____ Policy #:_____

Were the police notified? YES NO [ ] DON'T KNOW

Was an accident report filed? YES NO [ ] DON'T KNOW

("YOUR VEHICLE-" IS THE VEHICLE YOU WERE IN (ON) WHEN THE ACCIDENT OCCURRED)

Was the driver of your vehicle ticketed by the attending police officer? YES NO [ ] DON'T KNOW

Do you have personal injury protection (PIP) coverage? YES NO [ ] DON'T KNOW

Does the driver of your vehicle have PIP coverage? YES NO [ ] DON'T KNOW

Have you retained an attorney? YES NO If yes, Attorney's name:_____

THE FOLLOWING APPLY TO THE DRIVER OF THE OTHER VEHICLE

Drivers Name:_____

Address:_____

Auto Insurance CO:_____ Policy #:_____

Vehicle: Year:_____ Make:_____ Model:_____

WHEN / WHERE / CONDITIONS ("YOUR VEHICLE-" IS THE VEHICLE YOU WERE IN (ON) WHEN THE ACCIDENT OCCURRED)

Date of accident:_____ State of occurrence (e.g. WA, OR, CA):_____

Your vehicle: Year:_____ Make:_____ Model:_____

Light conditions: DAWN DAY LIGHT DUSK NIGHT/DARK

Road conditions: DRY WET ICE GRAVEL OTHER:_____

Weather conditions: CLEAR RAIN FOG CLOUDY OVERCAST SNOW OTHER:_____

AUTO RELATED ACCIDENT CONTINUED

AFTER THE INJURY

Did the accident render you unconscious? ..... yes no

If yes for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

Have you gone to a hospital or seen any other Doctor for this condition? Yes or no

When did you go? _____Just after the accident, _____ The next day, _____2 days plus

How did you get there? _____ Ambulance/aid car _____ private transportation

Name and address of hospital or other Dr._____

Describe any treatment that you received: _____

Were X-rays taken? ..... yes no
Was medication prescribed?.....yes no
Have you been able to work since the injury?.....yes no Did you miss any work since the injury? Yes or no
Are your work activities restricted as a result of this injury? .....yes no

Indicate the symptoms that are a result of this accident:

___Dizziness	___ Difficulty sleeping	___ Jaw problems	___ Nausea
___ Memory loss	___ Irritability	___ Arms/Shoulder pain	___ Back pain
___ Headaches	___ Fatigue	___ Numb Hands/fingers	___ Lower back pain
___ Blurred vision	___ Tension	___ Chest pain	___ Back Stiffness
___ Buzzing in ears	___ Neck pain	___ Shortness of breath	___ Leg pain
___ Ears ringing	___ Neck stiff	___ Stomach upset	___ Numbness feet/toes

Other: _____

Is your condition getting worse? Yes No constant comes and goes

Indicate your degree of comfort while performing the following activities:

	COMFORTABLE	*UNCOMFORTABLE*	*PAINFUL*
Lying on back	_____	_____	_____
Lying on side	_____	_____	_____
Lying on stomach	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Stretching	_____	_____	_____
Love making	_____	_____	_____
Walking	_____	_____	_____
Running	_____	_____	_____
Sports	_____	_____	_____
Working	_____	_____	_____
Lifting	_____	_____	_____
Bending	_____	_____	_____
Kneeling	_____	_____	_____
Pulling	_____	_____	_____
Reaching	_____	_____	_____

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform:

___ Standing ___ Driving ___ Operating Equipment
___ Sitting ___ Twisting ___ Work arms over head
___ Walking ___ Crawling ___ Typing
___ Lifting ___ Bending ___ Stooping
Other: _____

What positions can you work in with minimum physical effort and for how long _____

Prior to the accident were you capable of working on an equal basis with others your age? Yes No

DESCRIPTION OF THE ACCIDENT

Please describe the accident:_____

_____

_____

_____

_____

_____

NATURE OF THE ACCIDENT

Did the vehicle you were in have [ ] AUTOMATIC or [ ] MANUAL transmission?

Where were you seated in the vehicle? DRIVER [ ]

FRONT PASSENGER: [ ] MIDDLE [ ] BY DOOR

REAR PASSENGER: [ ] RIGHT [ ] MIDDLE [ ] LEFT

OTHER:_____

How many hands did you have on the steering wheel? [ ] ZERO [ ] ONE [ ] TWO

Did the air bag deploy? YES NO

Were you wearing a seat belt YES NO If yes, [ ] LAP BELT [ ] SHOULDER BELT [ ] BOTH

Did you receive any injury or bruise from the air bag or seat belt? YES NO If yes, describe:_____

_____

Does your vehicle have a head rest? YES NO If yes, was it [ ] HIGH [ ] MID [ ] LOW [ ] INTEGRAL

Was the driver applying the brake at impact? YES NO [ ] DON'T KNOW

Was your vehicle stopped at impact? YES NO [ ] DON'T KNOW

If your vehicle was moving at impact, was it:

Slowing down? YES NO

Gaining speed? YES NO

Traveling at a steady speed? YES NO

Estimate the speed of the vehicle you were in:_____ mph Km

Was the other vehicle moving at impact? YES NO [ ] DON'T KNOW

Were you aware of the approaching collision , or did the impact catch you by surprise? AWARE SUPRISE

Was your head pointed straight ahead at impact? YES NO If no, turned [ ] RIGHT [ ] LEFT

Was the trunk of your body pointed straight ahead at impact? YES NO If no, turned [ ] RIGHT [ ] LEFT

Did your body go [ ] forward then backward [ ] backward then forward [ ] other:_____

Functional Rating Index – Neck/Back

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In order to properly assess your condition, we must understand how much your neck and or back problems have affected your ability to manage everyday activities. As you read the list, **think of yourself *today***. *Please circle the number that **most closely** describes your condition **right now.***

Section 1: Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst Possible pain

Section 2: Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

Section 3: Personal Care (washing, dressing etc.)

0	1	2	3	4
No Pain; no restrictions	Mild pain; no restrictions	Moderate pain, need to go slowly	Moderate pain; need assistance	Severe pain; need 100% assistance

Section 4: Traveling

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

Section 5: Work

0	1	2	3	4
Can do usual work, + unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Section 6: Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

Section 7: Frequency of Pain

0	1	2	3	4
No Pain	Occasional pain; 25% of day	Intermittent pain; 50% of day	Frequent pain; 75% of day	Constant pain; 100% of day

Section 8: Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Section 9: Walking

0	1	2	3	4
No Pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

Section 10: Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient Name_____ Patient Signature_____ Date_____

Headache Disability Index

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Please circle the correct response:

1. I have a headache: 1 per month (1) More than 1 but less than 4 per month (2) More than 1 per week (3)
2. My headache is: Mild (1) Moderate (2) Severe (3)

Please read carefully: The purpose of this scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES" or "NO" to each item.

YES	SOMETIMES	NO		
☐	☐	☐	1.	Because of my headaches I feel handicapped.
☐	☐	☐	2.	Because of my headaches I feel restricted in performing my routine daily activities.
☐	☐	☐	3.	No one understands the effect my headaches have on my life.
☐	☐	☐	4.	I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.
☐	☐	☐	5.	My headaches make me angry.
☐	☐	☐	6.	Sometimes I feel that I am going to lose control because of my headaches.
☐	☐	☐	7.	Because of my headaches I am less likely to socialize.
☐	☐	☐	8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
☐	☐	☐	9.	My headaches are so bad that I feel that I am going to go insane.
☐	☐	☐	10.	My outlook on the world is affected by my headaches.
☐	☐	☐	11.	I am afraid to go outside when I feel that a headache is starting.
☐	☐	☐	12.	I feel desperate because of my headaches
☐	☐	☐	13.	I am concerned that I am paying penalties at work or at home because of my headaches.
☐	☐	☐	14.	My headaches place stress on my relationships with family or friends.
☐	☐	☐	15.	I avoid being around people when I have a headache.
☐	☐	☐	16.	I believe my headaches are making it difficult for me to achieve my goals in life.
☐	☐	☐	17.	I am unable to think clearly because of my headaches.
☐	☐	☐	18.	I get tense (e.g., muscle tension) because of my headaches.
☐	☐	☐	19.	I do not enjoy social gatherings because of my headaches.
☐	☐	☐	20.	I feel irritable because of my headaches.
☐	☐	☐	21.	I avoid traveling because of my headaches.
☐	☐	☐	22.	My headaches make me feel confused.
☐	☐	☐	23.	My headaches make me feel frustrated
☐	☐	☐	24.	I find it difficult to read because of my headaches
☐	☐	☐	25.	I find it difficult to focus my attention away from my headaches and on other things.

Patient Name_____ Patient Signature_____ Date_____

Whiplash Disability Questionnaire

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In order to properly assess your condition, we must understand how much your whiplash injury has affected your ability to manage everyday activities. As you read the list, **think of yourself *today***. *Please circle the number that **most closely** describes your condition **right now.*** If not applicable to you, state N/A.

1) How much pain do you have today?

0 1 2 3 4 5 6 7 8 9 10

0 = no pain — 10= Worst pain imaginable

2) Do your whiplash symptoms interfere with your personal care? (washing, dressing etc.)

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to perform

3) Do your whiplash symptoms interfere with your work / home / study duties?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to perform

4) Do your whiplash symptoms interfere with driving or using public transportation?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to travel in car/public

5) Do your whiplash symptoms interfere with sleep?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Cannot sleep

6) Do you feel more tired / fatigued than usual since your injury?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Always

7) Do your whiplash symptoms interfere with social activity?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to socialize

8) Do your whiplash symptoms interfere with sporting leisure activity?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to participate

9) Do your whiplash symptoms interfere with non-sporting leisure activity?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to participate

10) Do you experience sadness / depression as a result of your whiplash injury / symptoms?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Always

11) Do you experience anger as a result of your whiplash injury / symptoms?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Always

12) Do you experience anxiety as a result of your whiplash injury / symptoms?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Always

13) Do you have difficulty concentrating as a result of your whiplash injury / symptoms?

0 1 2 3 4 5 6 7 8 9 10

0 = not at all — 10= Unable to concentrate

Patient Name_____ Patient Signature_____ Date_____

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Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage everyday life. **Please answer every section *and mark in each section only the one box that* applies to you.** We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed; for example, on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5: Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches, which come infrequently
- ☐ I have moderate headaches, which come infrequently
- ☐ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently
- ☐ I have headaches almost all the time

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

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Section 7: Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

Section 8: Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

Section 9: Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- ☐ I am able to engage in all my recreational activities with no neck pain at all
- ☐ I am able to engage in all my recreational activities, with some pain in my neck
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

Patient Name_____ Patient Signature_____ Date_____

Score: _____/50 **`Transform to percentage score x 100 = _____% points**

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: *Example: 16 (total scored); 50 (total possible score) x 100 = 32%*

If one section is missed or not applicable the score is calculated: *16 (total scored); 45 (total possible score) x 100 = 35.5%*

Minimum Detectable Change (90% confidence): 5 points or 10 % points

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415

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The Roland-Morris Disability Questionnaire

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*.

As you read the list, **think of yourself *today***. *When you read a sentence that describes you today, circle the number.* If the sentence does not describe you, do not circle it and go on to the next one. Remember, only circle the sentence if you are sure it describes you today.

1. I stay at home most of the time because of my back.
2. I change position frequently to try and get my back comfortable.
3. I walk more slowly than usual because of my back.
4. Because of my back I am not doing any of the jobs that I usually do around the house.
5. Because of my back, I use a handrail to get upstairs.
6. Because of my back, I lie down to rest more often.
7. Because of my back, I have to hold on to something to get out of a chair.
8. Because of my back, I try to get other people to do things for me.
9. I get dressed more slowly than usual because of my back.
10. I only stand for short periods of time because of my back.
11. Because of my back, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of my back.
13. My back is painful almost all the time.
14. I find it difficult to turn over in bed because of my back.
15. My appetite is not very good because of my back pain.
16. I have trouble putting on my socks (or stockings) because of the pain in my back.
17. I only walk short distances because of my back.
18. I sleep less well because of my back.
19. Because of my back pain, I get dressed with help from someone else.
20. I sit down for most of the day because of my back.
21. I avoid heavy jobs around the house because of my back.
22. Because of my back pain, I am more irritable and bad tempered with people than usual.
23. Because of my back, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of my back.

Patient Name_____ Patient Signature_____ Date_____

This questionnaire is taken from: Roland MO, Morris RW. A study of the natural history of back pain. Part 1: Development of a reliable and sensitive measure of disability in low back pain. Spine 1983; 8: 141-144. The score of the RDQ is the total number of items checked – i.e. from a minimum of 0 to a maximum of 24.

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NOTICE OF PRIVACY PRACTICES

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

Understanding Your Health Record/Information:

This medical practice collects health information about you and stores it in both a physical file and on a computer. This information is updated each time you are seen by one of our practitioners. Typically, this information contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment;
- means of communication among the many health professionals who contribute to your care;
- legal document describing the care you received;
- means by which you or a third party payer can verify that services billed were actually provided;
- a tool in educating heath professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing;
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper or electronic copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend or supplement your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request confidential communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information we maintain, regardless of when it was created or received. A current copy will be available for review at each appointment.

We understand the importance of privacy and are committed by law to maintaining the confidentiality of your medical information. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you would like additional information, you may contact our office manager at (425) 888-6846. You may also contact the Director of Health Information Management at (444) 111-1111.

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

NOTICE OF PRIVACY PRACTICES

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Examples of Disclosures for Treatment, Payment and Health Operations

The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and other professionals who are involved in providing the care you need. For example, we may share your medical information via copies of records or reports or phone calls with other physicians or health care providers who will provide subsequent services that we do not provide or who work in conjunction with our services to provide you with the most effective care and treatment.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. A bill may be sent to you or a third party payer which identifies you, as well as your diagnosis, procedures and supplies used. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information as part of our effort to review and continually improve the quality and effectiveness of service we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. Your information may also be shared with other health care providers, health care clearing houses who perform administrative services for us, or health plans that have a relationship with you when they request the information to help them with their quality assessment and improvement activities, their patient-safety activities, or their population based efforts to improve health or reduce health care costs.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include radiology or certain laboratory tests. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard the confidentiality and security of your information.

Notification and Communication with Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may override your objection if the situation is rendered an emergency. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and friends.

Disclosures to Health Plans: At your request, we cannot disclose information about care you have paid for out-of-pocket to health plans unless for treatment purposes or in the rare event the disclosure is required by law.

Disclosures to Protective Services: If the healthcare provider has reasonable cause to believe that a child or a disabled adult is in need of protective services, or that you are a clear imminent danger to yourself or another person, appropriate authorities are contacted.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sale of Health Insurance: We will not sell your health insurance information without your prior written authorization.

Marketing: Provided we receive no compensation for making these communications, we may contact you face to face to give you information about products or services related to your treatment, treatment alternatives or other health related benefits and services that may be of interest to you in the absence of your written authorization. This communication shall be restricted by law to general health promotion rather than the promotion of a specific product or service, a drug or biologic the patient is currently being prescribed, or involves government or government sponsored programs.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, reporting domestic violence, or reporting child, elder or dependent adult abuse or neglect.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

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NOTICE OF PRIVACY PRACTICES

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you unless after completing a risk analysis as dictated by law it is determined that there is a "low probability of PHI compromise". Notification will be by either email or phone.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are not potentially endangering one or more patients, workers, or the public.

Acknowledgement of Review and Receipt of Notice of Privacy Practices

- ❑ I hereby acknowledge receipt of a copy of this Notice of Privacy Practices.
- ❑ I have reviewed and been offered a copy of this Notice of Privacy Practices but do not wish to receive it at this time.
- ❑

Signed: _____ Print Name: _____

Effective Date: _____ If not signed by patient, indicate relationship: _____

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Consent to receive SMS

By signing below and supplying my phone number, email address, and any other personal contact information, I authorize Alpine Chiropractic Center to use SMS messaging to communicate with me regarding scheduled or missed appointments, patient waitlist and recall, account balance notifications and statements, as well as other Protected Health Information. I authorize Alpine Chiropractic Center to use an automated outreach and messaging system for certain reminders and notifications. I consent to receive multiple and/or recurring SMS messages and understand that messaging frequency varies and messaging and data rates may apply.

For Text Message Services, text HELP to the sending number with questions and text STOP to that number to Opt-out. Your Opt-out request may generate a confirmation text.

Signature:_____ Date:_____

Printed Name:_____