

**PATIENT INFORMATION:**       Male /       Female  
**PASIENTE INFORMACION:**       Masculino /       Femenino  
**TÀI LIỆU CỦA BỆNH NHÂN:**       NAM /       NỮ

Name / *Nombre* / TÊN HỌ: \_\_\_\_\_

Date of Birth / *Fecha de Nacimiento* / NGÀY SANH: \_\_\_\_\_ Age / *Edad* / TUỔI: \_\_\_\_\_

Address / *Direccion Domicilio* / ĐỊA CHỈ: \_\_\_\_\_

City / *Ciudad* / THÀNH PHỐ: \_\_\_\_\_ State / *Estado* / TIỂU BANG: \_\_\_\_\_

Zip Code / *Codigo Postal* / ZIP CODE: \_\_\_\_\_

Social Security # / *# de S.S.* / SỐ SOCIAL SECURITY: \_\_\_\_\_

Driver's License # / *Licencia de Conducir #* / SỐ BẰNG LÁI XE: \_\_\_\_\_

Home Phone / *Telefono de su casa* / ĐIỆN THỌAI NHÀ: (\_\_\_\_) \_\_\_\_\_

Work Phone / *Telefono de empleo* / ĐIỆN THỌAI SỐ LÀM: (\_\_\_\_) \_\_\_\_\_

Employer / *Nombre de compañía* / TÊN CỦA SỐ LÀM: \_\_\_\_\_

Occupation / *Occupacion* / NGHỀ NGHIỆP: \_\_\_\_\_

**RESPONSIBLE PARTY:** *If the patient is a minor under the age of 18 years, please complete this section.*  
**RESPONSABLE PARTY:** *Si el paciente es menor de edad, por favor llene esta seccion.*  
**NGƯỜI CHỊU TRÁCH NHIỆM:** NẾU BỆNH NHÂN DƯỚI 18 TUỔI, CHA MẸ HOẶC NGƯỜI THÂN CẦN ĐIỀN VÀO PHẦN NÀY.

Name / *Nombre* / TÊN HỌ: \_\_\_\_\_

Date of Birth / *Fecha de Nacimiento* / NGÀY SANH: \_\_\_\_\_ Age / *Edad* / TUỔI: \_\_\_\_\_

Relationship / *Relacion* / QUAN HỆ: \_\_\_\_\_

Social Security # / *# de S.S.* / SỐ SOCIAL SECURITY: \_\_\_\_\_

Driver's License # / *Licencia de Conducir #* / SỐ BẰNG LÁI XE: \_\_\_\_\_

Home Phone / *Telefono de su casa* / ĐIỆN THỌAI NHÀ: (\_\_\_\_) \_\_\_\_\_

Work Phone / *Telefono de empleo* / ĐIỆN THỌAI SỐ LÀM: (\_\_\_\_) \_\_\_\_\_

Employer / *Nombre de compañía* / TÊN CỦA SỐ LÀM: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION / EN CASO DE EMERGENCIA INFORMACION / XIN GHI TÊN THÂN NHÂN PHÔNG HỌ KHI CÓ TRƯỜNG HỢP KHẨN CẤP:**  
 Nearest Relative's Name / *Familiar cercano (nombre)* / TÊN HỌ CỦA THÂN NHÂN: \_\_\_\_\_

Home # / *Numero de telefono* / ĐIỆN THỌAI NHÀ: (\_\_\_\_) \_\_\_\_\_

Relationship / *Relacion* / QUAN HỆ: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**       YES / SI / CÓ  
**INFORMACION DE ASEGURANZA MEDICA:**       NO / Ninguna / KHÔNG CÓ  
**QUÝ VỊ CÓ BẢO HIỂM SỨC KHỎE HAY KHÔNG?:**       AHCCCS

Insurance Company / *Compañia de aseguranza* / TÊN CỦA HÃNG BẢO HIỂM: \_\_\_\_\_

Insured's Name / *Nombre de asegurado* / TÊN HỌ CỦA NGƯỜI ĐỨNG TÊN: \_\_\_\_\_

Insurance Phone # / *Telefono de aseguranza* / ĐIỆN THỌAI CỦA HÃNG BẢO HIỂM: (\_\_\_\_) \_\_\_\_\_

Relationship to Insured / *Relacion* / QUAN HỆ VỚI BỆNH NHÂN: \_\_\_\_\_

Insured's ID# / *# de tarjeta* / SỐ ID#: \_\_\_\_\_

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

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

**PERSONAL AUTO INSURANCE INFORMATION:**  None/ *Ninguna* / **KHÔNG CÓ**  
**INFORMACION PERSONAL DE ASEGURANZA DE SU VEHICULO:**  
**BẢO HIỂM XE:**

Insurance Company / *Compañia de aseguranza* / TÊN CỦA HÃNG BẢO HIỂM: \_\_\_\_\_

Insured's Name / *Nombre de asegurado* / TÊN HỌ CỦA NGƯỜI ĐÚNG TÊN: \_\_\_\_\_

Insurance Phone # / *Telefono de aseguranza* / ĐIỆN THỌAI CỦA HÃNG BẢO HIỂM: (\_\_\_\_) \_\_\_\_\_

Policy # / *Poliza #* / SÔ POLICY: \_\_\_\_\_ Claim # / *# Reclamo* / SÔ CLAIM: \_\_\_\_\_

**Have you reported the accident to your insurance? / ¿A reportado el accidente a su aseguransa?**  
**QUÝ VỊ CÓ BÁO TAI NẠN VỚI BẢO HIỂM CHƯA?  YES/ *SI* / CÓ  NO / *NO* / KHÔNG**

**OTHER PARTY'S AUTO INSURANCE INFORMATION / INFORMACION DE ASEGURANZA DEL**  
**PARTIDO RESPONSIBLE / BẢO HIỂM XE CỦA NGƯỜI ĐỐI DIỆN:**

Insurance Company / *Compañia de aseguranza* / TÊN CỦA HÃNG BẢO HIỂM: \_\_\_\_\_

Insured's Name / *Nombre de asegurado* / TÊN HỌ CỦA NGƯỜI ĐÚNG TÊN: \_\_\_\_\_

Insurance Phone # / *Telefono de aseguranza* / ĐIỆN THỌAI CỦA HÃNG BẢO HIỂM: (\_\_\_\_) \_\_\_\_\_

Policy # / *Poliza #* / SÔ POLICY: \_\_\_\_\_ Claim # / *# Reclamo* / SÔ CLAIM: \_\_\_\_\_

**ACCIDENT QUESTIONS / NATURALEZA DE ACCIDENTE / CÂU HỎI VỀ TAI NẠN:**

1. Date of accident / *Fecha de accidente* / NGÀY TAI NẠN XẢY RA: \_\_\_\_\_
2. Time of day / *Tiempo del dia* / VÀO LÚC GIỜ NÀO: \_\_\_\_\_ AM/PM
3. Were you the: / *Fue usted:* / QUÝ VỊ LÀ:  Driver / *Conductor* / NGƯỜI LÁI XE  Passenger / *Pasajero* / HÀNH KHÁCH
4. How many people were in your vehicle (including yourself)? / *Numero de personas en su vehiculo (inclusivo usted)* / CÓ TẤT CẢ BAO NHIÊU NGƯỜI TRONG XE? \_\_\_\_\_
5. On what street or intersection did the accident occur? / *¿En que calle se iba dirijiendo?*  
 TAI NẠN XẢY RA TRÊN ĐƯỜNG NÀO? \_\_\_\_\_
6. Did the accident take place in a parking lot? / *¿El accidente ocurrio en un estacionamiento?* /  
 TAI NẠN CÓ XẢY RA TRONG CHỖ ĐẬU XE KHÔNG?  Yes/ *Si* / CÓ  No / *No* / KHÔNG
7. Did the accident occur on private property? / *¿El accidente ocurrio en alguna propiedad privada?* /  
 TAI NẠN CÓ XẢY RA TRÊN PHÂN ĐẤT CỦA NGƯỜI KHÁC HAY KHÔNG? VÍ DỤ: XE TÔNG VÀO NHÀ,  
 HÃNG RÃO  Yes/ *Si* / CÓ  No / *No* / KHÔNG
8. On impact, were you struck from: / *Fue golpeado por:* / QUÝ VỊ BỊ ĐỤNG XE Ở PHIÁ NÀO?  
 Behind / *Atras* / SAU  Front / *De frente* / TRƯỚC  
 Left Side / *Izquierda* / BÊN HÔNG TRÁI  Right Side / *Derecha* / BÊN HÔNG PHẢI
9. Year, make and model of your vehicle: / *Año, marca y modelo de su vehiculo:* /  
 NĂM VÀ LOẠI XE CỦA QUÝ VỊ: \_\_\_\_\_
10. Were you driving or riding in: / *Estaba manejando o era pasajero en:* / XE QUÝ VỊ LÁI HOẶC LÀ HÀNH KHÁCH CỦA XE:  
 Own vehicle / *Vehiculo propio* / NHÀ  Friend's vehicle / *Vehiculo de un amigo* / BẠN  
 Work vehicle / *Vehiculo del trabajo* / SỞ LÀM
11. Were police notified and at the scene? / *¿Fue la policia notificada y presente en el accidente?* / CẢNH SÁT CÓ TỚI NƠI  
 XẢY RA TẠI NẠN KHÔNG?  Yes/ *Si* / CÓ  No / *No* / KHÔNG
12. Whom did the police ticket and why? / *¿La policia multo a alguien y porque?* / CẢNH SÁT CÓ PHẠT AI HAY KHÔNG  
 VẬ TẠI SAO? \_\_\_\_\_

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

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

**REASON FOR YOUR VISIT / CUAL ES LA RAZON DE SU VISITA / LÝ DO QUÝ VỊ ĐẾN VĂN PHÒNG CHÚNG TÔI:**

1. When did you first begin having problems? / ¿Cuándo empecé a sentir problemas? / NHỮNG VẾT THƯƠNG HOẶC CHỖ ĐAU BẮT ĐẦU TỪ LÚC NÀO? \_\_\_\_\_

2. Are there any activities that make your pain worse? / ¿Hay alguna actividad que haga que sienta más dolor? / CÓ NHỮNG CHUYỆN LÃM NÃO, LÃM CHO VẾT THƯƠNG THÊM TRÂM TRỌNG KHÔNG?

3. Do your current problems interfere with: / ¿Su problema presente interfiere con su: / NHỮNG VẾT THƯƠNG CÓ CẢN TRỞ VỚI:  Work / Trabajo / VIỆC LÀM  Sleep / Cuando duerme / NGỦ  
 Daily activities / Actividades diarias / CHUYỆN THƯỜNG NGÀY

4. Have you lost any time from work due to your problems? / ¿Perdió tiempo del trabajo como resultado del accidente? / QUÝ VỊ CÓ PHẢI NGHỈ LÀM SAU KHI BỊ TAI NẠN HAY KHÔNG?

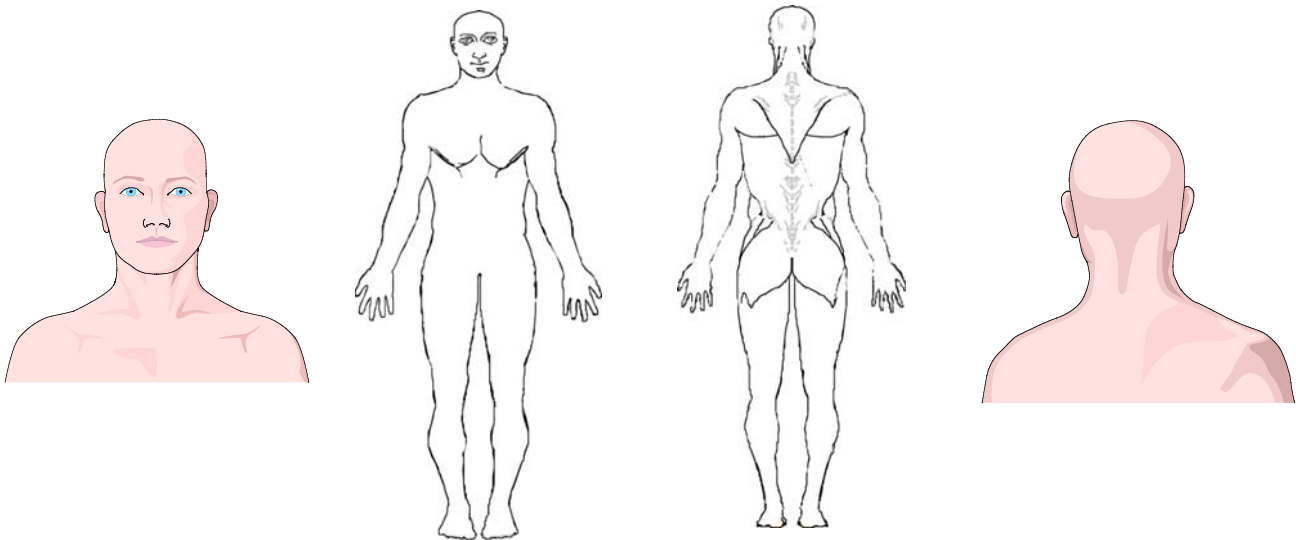
Yes / Si / CÓ  No / No / KHÔNG

5. Are your symptoms currently: / ¿Siente que su problema esta: / BÂY GIỜ QUÝ VỊ CẢM THẤY NHỮNG VẾT THƯƠNG  
 Improving / Mejorando / TIẾN BỘ  Getting Worse / Empeorando / THÊM TRÂM TRỌNG  
 No Change / Igual / NHƯ THƯỜNG

6. Place an "x" on the drawings below to show any areas where you are having pain:

*Ponga una "x" en el dibujo, marcando las áreas en las que tiene dolor:*

XIN QUÝ VỊ ĐÁNH CHỮ "X" VÀO TRONG HÌNH NHỮNG CHỖ NÀO QUÝ VỊ CẢM THẤY ĐAU NHỨC:



7. Please mark any and all of the following that apply: /

*Por favor marque cualquiera de los siguientes síntomas que sienta: /*

XIN QUÝ VỊ ĐÁNH DẤU VÀO TẤT CẢ CÁC KHUNG NÀO QUÝ VỊ CẢM THẤY TRONG NGƯỜI BÂY GIỜ:

- |  |   |
|--|---|
| <input type="checkbox"/> Swollen joints / Ligamentos inflamados / KHỚP XƯƠNG BỊ XŨNG | <input type="checkbox"/> Vomiting / Vomito / CÓ ÓI MÚA          |
| <input type="checkbox"/> Sore muscles / Musculos inflamados / BẮP THỊT NHỨC MỎI      | <input type="checkbox"/> Nausea / Nausea / CÓ BUỒN NÔN          |
| <input type="checkbox"/> Weak muscles / Musculos debiles / BẮP THỊT CẢM THẤY YÊU     | <input type="checkbox"/> Headaches / Dolor de cabeza / NHÚT ĐẦU |
| <input type="checkbox"/> Broken bones / Huesos rotos / GÃY XƯƠNG                     | <input type="checkbox"/> Dizziness / Mareos / CHÓNG MẶT         |
| <input type="checkbox"/> Walking problems / Problemas caminar / KHÓ ĐI ĐỨNG          | <input type="checkbox"/> Poor Sleep / Falta de sueño / MẤT NGỦ  |

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

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

**MEDICAL HISTORY: / HISTORIA MEDICA/ HỒ SƠ BỆNH LÝ**

1. Did you lose consciousness during the accident? If yes, for how long? / ¿Fue golpeado inconsciente? Si, por cuanto tiempo? / QUÝ VỊ CÓ BỊ BẤT TỈNH HAY KHÔNG? NẾU CÓ, QUÝ VỊ BỊ BẤT TỈNH KHỔNG BAO LÂU?  
 Yes/ Si / CÓ \_\_\_\_\_  No / No / KHÔNG

2. If you were seen at the hospital after the accident, please list which hospital. / Si uste fue visto en un hospital despues del accidente por favor liste el nombre del hospital./ NẾU QÚI VỊ CÓ ĐI BỊNH VIỆN SAU KHI TAI NẠN, XIN GHI TÊN BỊNH VIỆN. /

3. List all other doctors you have seen for your problems. / Liste otros doctores que haya visto por este problema / XIN QÚI VỊ GHI TÊN BÁC SĨ NẾU QUÝ VỊ CÓ ĐI BÁC SĨ NÀO KHÁC SAU KHI BỊ TAI NẠN

4. List previous accidents including dates. / Escriba previos accidentes y las fechas / XIN QÚI VỊ CHO CHÚNG TÔI BIẾT NẾU TRƯỚC ĐÂY CÓ BỊ TAI NẠN XE CỘ (XIN GHI VÀO THÁNG VÀ NĂM TAI NẠN XẢY RA):

5. List previous surgeries including dates / Escriba previas cirugias y las fechas / XIN QÚI VỊ CHO CHÚNG TÔI BIẾT NẾU TRƯỚC ĐÂY QUÝ VỊ CÓ GIẢI PHẪU:

6. List any treatment received from a doctor for any health condition in the past year: / Escriba cualquier tratamiento recibido de cualquier doctor en el año pasado / XIN CHO CHÚNG TÔI BIẾT NẾU QUÝ VỊ CÓ ĐI BÁC SĨ NÀO KHÁC ĐỂ TRỊ BỆNH TRONG VÕNG MỘT NĂM NAY?:

**7. WOMEN / MUJERES / PHU NU:**  
**Are you currently pregnant? / ¿Esta usted embarazada? / QUÝ VỊ HIỆN BÂY GIỜ CÓ THAI KHÔNG?**  
 Yes/ Si / CÓ  No / No / KHÔNG

In your own words, please describe the accident:/ En sus propias palabras, por favor describa el accidente:/ XIN QUÝ VỊ VUI LÒNG TUÔNG THUẬT LẠI LÀM SAO TAI NẠN XẢY RA:

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

**Print Name of Person Completing Form:** \_\_\_\_\_

**Relationship to Patient:**  Self  Parent  Other \_\_\_\_\_

**AUTHORIZATION & ASSIGNMENT OF BENEFITS:** I, the undersigned patient and/or responsible party, authorize Injury Chiropractic (the "Center") to release any medical records and billing information to the health insurance, workers' compensation and/or auto insurance companies for charges incurred at the Center. In addition, I authorize and assign appeal rights to the Center. I also authorize assignment and lien against any third party whose negligence may have caused me to seek treatment at the Center. Finally, I authorize, assign and direct all insurance carriers to directly reimburse the Center. **Medical payments carriers are authorized to pay Injury Chiropractic directly under this assignment of benefits. All payments should be mailed directly to: Injury Chiropractic at 7333 West Thomas Road, Suite 40, Phoenix, Arizona 85033-5548.**

**CONSENT TO TREAT:** Chiropractic care is a non-invasive approach with some of the safest outcomes in health care. I understand that the Center cannot promise a complete recovery but will provide the best care possible and address any concerns. Furthermore, I have been advised I may experience temporary symptoms like soreness following manipulation or traction and skin irritation after ice, heat, ultrasound or EMS. I am aware that in rare instances, manipulation can cause aggravation to bulging/ herniated disc or cause a rib fracture, and even more rarely, cervical manipulation can be related to compromised vertebral artery and possible stroke symptomatology. Understanding the limitations and possible complications of receiving chiropractic care, I hereby authorize the Center to examine, take x-rays and provide treatment that is deemed medically necessary for my condition or my minor child's condition.

**HIPAA PRIVACY PRACTICES:** On a separate form, our office has supplied you with a copy of our office's HIPAA Notice of Privacy Practices. My initialing of this section as well as my signature below is only an acknowledgment that I have received a copy of this Notice. **Initials Here:** \_\_\_\_\_

**FINANCIAL RESPONSIBILITY:** I agree that health and accident insurance policies are an arrangement between the insurance carrier and the insured. Even though I authorize insurance carriers to assign benefits directly to Injury Chiropractic, I clearly understand and agree that all services rendered are charged directly to me and that by signing below I accept personal responsibility for payment of said services.

**In the event that I receive any check, draft, or other payment for services provided by Center, I agree to act as the fiduciary agent for the Center by IMMEDIATELY delivering said payment to the Center. Additionally, I hereby assign Power of Attorney to the Center and its assignee to endorse/sign my name on any and all checks and payments, for my indebtedness to the Center.** In addition, the Center and I jointly agree to have a method of resolving disagreement, misunderstanding or disputes, should they occur, privately, quickly, economically and in a friendly, educational manner using the communication, negotiation, mediation and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement.

Furthermore, I understand that if the Center must employ collection counsel and/or legal counsel to obtain payment for my debt, that I will be responsible for any and all collection fees, interest fees and reasonable attorney's fees. I hereby waive the Statute of Limitations regarding the Center's right to recover.

My signature below confirms that I understand and agree to comply with all parts of this document. I, the undersigned patient and/or responsible party, state that all information provided on intake has been true and correct to the best of my knowledge.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Responsible Party Name

\_\_\_\_\_  
Print Patient's Name (if minor)

***A PHOTOCOPY OF THIS FORM SHALL BE DEEMED AS VALID AS THE ORIGINAL***

(REVISED 11/8/06)

**INJURY CHIROPRACTIC**  
7333 W. Thomas Road, Suite 40 Phoenix, Arizona 85033-5548  
Phone (623) 849-1736 ♦ FAX (623) 849-0406

**STANDARD AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH**

**INFORMATION:** I, the undersigned patient or patient representative, do hereby authorize Injury Chiropractic (the "Center") and its staff to furnish my legal representative with the following information. **In addition, I authorize my legal representative to provide all the following information to the Center:** •complete medical records •treatment status •insurance information •correspondence

**This authorization is effective from today lasting for a period of five (5) years unless revoked or terminated by the party signing below.** A written revocation to the attention of the HIPAA Compliance Officer to the above address is required to revoke or terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**AGREEMENT ON PERSONAL INJURY RECOVERY:** I, the undersigned, hereby authorize and direct said Attorney to pay directly to the Center such sums as may be due and owing for services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the Center. Furthermore, I authorize this lien to the Center against all proceeds of any settlement, judgment or verdict that may be paid to me.

I fully understand and acknowledge that I am directly and fully responsible to the Center for all services rendered to me and that this Agreement is made solely for the Center's additional protection and in consideration of the Center's agreement to postpone demand for payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover all or any portion of the sums owed to the Center.

I agree never to rescind the Agreement portion of this document and that any attempt to rescind will not be honored by my Attorney. In the event of new legal representation, I authorize the new legal representative to honor this lien as inherent to the settlement and enforceable upon the case as if he/she originally executed it.

\_\_\_\_\_

Dated

\_\_\_\_\_

Responsible Party's Signature

\_\_\_\_\_

Patient's Name (if minor)

\_\_\_\_\_

Printed Responsible Party's Name & Relationship to Patient

The undersigned Attorney of record agrees to promptly notify the Center if Attorney ceases to represent or when any change in representation occurs. Attorney shall also promptly deliver a copy of this Agreement to any additional or substitute legal counsel. Furthermore, Attorney does hereby agree to observe all the terms of this Agreement stated above.

\_\_\_\_\_

Dated

\_\_\_\_\_

Attorney/Legal Representative

***A PHOTOCOPY OF THIS FORM SHALL BE DEEMED AS VALID AS THE ORIGINAL***

75<sup>th</sup>

19<sup>th</sup>

16<sup>th</sup>

Mesa

(REVISED 11/8/06)

# HIPAA Notice of Privacy Practices

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***Injury Chiropractic***  
***7333 W. Thomas Road, Suite 40***  
***Phoenix, Arizona 85033***  
***(623) 849-1736***

**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.**

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

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, 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 may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**INJURY CHIROPRACTIC**  
**NOTICE OF PRIVACY PRACTICES**  
**PAGE TWO**

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved 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. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office at 623-849-1736.

**PLEASE GIVE THE PATIENT A COPY OF THIS NOTICE**