CLEAR
SCOLIOSIS CENTER

New Scoliosis Patient Paperwork

Welcome to our office!

Please take the time to fill out this packet in full.

Do not leave any questions blank.

If you require any assistance, please let a member of our office staff know, and we would be happy to assist you.

Thank you for coming! We are so glad you're here, and we look forward to serving you and your family in your journey towards optimum spinal health.

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Introduction

Welcome to the CLEAR Scoliosis Center! We are Delighted to have You as a Patient.

The purpose of this packet is to obtain as much information as possible about your scoliosis, and how it is affecting your physical and emotional well-being.

Please fill out this paperwork and send it to us in advance of your visit. This ensures we have time to review the information beforehand, and helps us to maximize the value of your time in our clinic.

Please do not leave any questions blank, as this could cause a delay on your first visit that may interfere with your treatment plan. If there are questions which you do not know the answer to, please write "I don't know" or "don't remember" so that we know the question was not skipped accidentally. If you have any questions, please let us know right away so that we may assist you. You can contact us by phone at 704-947-2902, or e-mail us any time at DRJUSTINDICK@GMAIL.COM.

There is a **Medical Records Release Form** on the very last page of this document; please sign and send a copy of this form to every doctor and clinic that has been involved in the care of your scoliosis. Keep in mind that it usually takes around 7 to 10 business days for clinics to process requests for records and deliver them to us, and allow for sufficient time between sending the request and your initial appointment, so that we may have time to review the records and ensure we have all of the necessary information.

If you are a parent filling out this form on behalf of your child, please do so together with your child, and allow them the opportunity to answer important questions on their own. It's important that we have an accurate understanding of how scoliosis is affecting their life so that we can tailor the treatment for their individual needs & concerns.

Thank you for taking the time to fill out these forms. We look forward to seeing you in the office!

For Office use Only

Height _____ Weight _____ Blood Pressure _____ Pulse _____

This Form Filled Out by: □ Patient □ Parent / Guardian: _____

PATIENT NAME _____ TODAY'S DATE: _____/_____/_____

DATE OF BIRTH _____/_____/_____ AGE _____ SSN _____-_____-_____

MOTHER'S NAME _____ FATHER'S NAME _____

BROTHERS / SISTERS: _____

CHECK ONE: ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MARRIED, SPOUSE'S NAME: _____

CHILDREN'S NAMES & AGES: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ MOBILE: _____

E-MAIL ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION FOR PATIENT REMINDERS: ☐ PHONE ☐ E-MAIL ☐ TEXT ☐ MAIL

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S OCCUPATION: _____ EMPLOYER: _____

NAME OF EMERGENCY CONTACT: _____ RELATION: _____

EMERGENCY CONTACT PHONE NO.: _____ ALT. PHONE: _____

GOVERNMENT EHR REGULATIONS REQUIRE PROVIDERS TO REPORT BOTH RACE AND ETHNICITY (YOU MAY DECLINE TO ANSWER)

RACE: ☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN-AMERICAN ☐ WHITE (CAUCASION)
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ OTHER ☐ DECLINE TO ANSWER

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO ANSWER

LANGUAGES SPOKEN (OPTIONAL): _____

HOW DID YOU HEAR ABOUT US? ☐ INTERNET SEARCH ☐ WORD OF MOUTH ☐ WALK – IN ☐ EXPO / EVENT

☐ REFERRED TO OUR OFFICE BY: _____ ☐ DC ☐ MD ☐ RN

☐ PLEASE CHECK THIS BOX IF YOU WOULD LIKE TO RECEIVE A FULL COPY OF YOUR TREATMENT NOTES & RECORDS AFTER EVERY VISIT

Your Current Health Status

Are you experiencing any of the following musculoskeletal symptoms?

☐ Headaches	☐ Neck Pain	☐ Left-sided Neck & Shoulder Pain	☐ Right-sided Neck & Shoulder Pain
☐ Upper Back Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Pain between the Shoulder Blades
☐ Hip Pain (L / R)	☐ Leg Pain (L / R)	☐ Knee Pain (L / R)	☐ Ankle Pain (L / R)
☐ Foot Pain (L / R)	☐ Jaw Pain	☐ Shoulder Pain (L / R)	☐ Wrist Pain (L / R)

☐ Other (please describe): _____

Do you have any other symptoms or conditions?

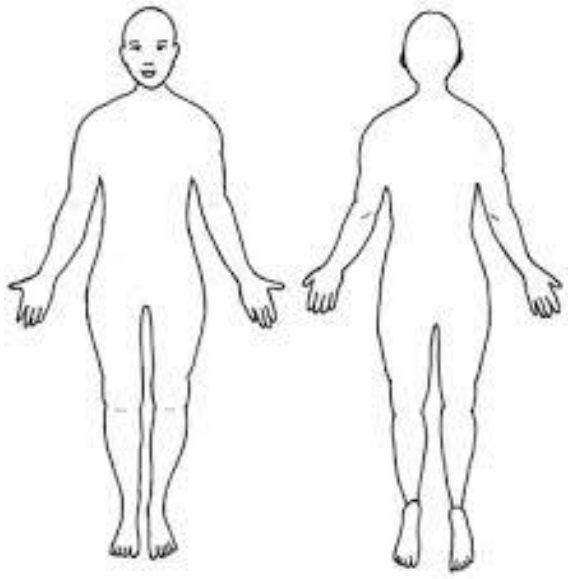
☐ Dizziness	☐ Forgetfulness	☐ Fainting	☐ Allergies
☐ Loss of Appetite	☐ Excessive Appetite	☐ Excessive Thirst	☐ Nausea
☐ Vomiting	☐ Constipation	☐ Hemorrhoids	☐ Liver Trouble
☐ Asthma	☐ Black or Bloody Stool	☐ Stomach Cramps	☐ Bladder Trouble
☐ Weight Trouble	☐ Gall Bladder Problems	☐ Fever	☐ Arthritis
☐ Varicose Veins	☐ Ankle Swelling	☐ Diarrhea	☐ Heart Problems
☐ Urinary Tract Infections	☐ Ear/Nose/Throat Infections	☐ Eczema/Skin Rash	☐ Epilepsy/Seizures
☐ Gas/Bloating After Meals	☐ Heartburn/Acid Reflux	☐ Diabetes	☐ Tiredness/Fatigue
☐ Difficulty Sleeping	☐ Numbness and Tingling	☐ Depression/Anxiety	☐ Breathing problems
☐ Painful/Excessive Urination	☐ Blood Pressure Problems	☐ Osteopenia/Osteoporosis	

☐ Other (please describe): _____

On the drawing to the right, please outline the area(s) of your discomfort.

Use the letters below to indicate the type of discomfort.

A = aching / soreness
B = burning pain
C = cramping
N = numbness
P = pins & needles / tingling
S = stabbing pain
T = stiffness



On a scale of zero (no pain) to 10 (worst pain imaginable), rate your current level of discomfort:

0 1 2 3 4 5 6 7 8 9 10

Scoliosis History

Who first noticed the scoliosis? (mark below) **When was it first noticed?** _____

□ Friend/Family Member □ School Screening □ Family Doctor □ Chiropractor □ Orthopedist

□ Other: _____

When was the first scoliosis x-ray taken? _____/_____/_____

What were the Cobb Angle measurements on the initial x-ray? _____

What were the initial recommendations? □ Observation □ Bracing □ Surgery □ Other: _____

Previous Treatment	Doctor Name	Treatment Duration	Treatment Effect
_____	_____	_____	better / same / worse
_____	_____	_____	better / same / worse
_____	_____	_____	better / same / worse

Have additional imaging procedures been performed, since the initial scoliosis x-ray?

□ MRI (Date: _____) □ CT Scan (Date: _____)

□ Follow-up X-rays (Dates: _____)

□ Other: _____

What were the Cobb Angle measurements on the most recent x-ray? _____

In your own words, please describe your experiences with the scoliosis diagnosis & treatment so far:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAST HEALTH HISTORY

PATIENT'S BIRTH HISTORY: □ VAGINAL □ C-SECTION □ FORCEPS/VACUUM ASSISTED □ VBAC □ WATER BIRTH

HOURS OF LABOR: _____ **BIRTH LOCATION:** □ HOSPITAL □ BIRTHING CENTER □ HOME BIRTH □ EMERGENCY SETTING

CHILDHOOD INJURIES: (PLEASE INCLUDE DATE OF INJURY) _____

_____

CHILDHOOD SURGERIES / ILLNESSES: □ TONSILLECTOMY □ APPENDECTOMY □ STREP THROAT □ MEASLES

□ CHICKEN POX □ WHOOPING COUGH □ PERTUSSIS □ MUMPS □ RUBELLA □ CHRONIC EAR INFECTIONS

□ OTHER, PLEASE DESCRIBE: _____

ADDITIONAL INJURIES (WORK, SPORTS, HOME): □ BROKEN BONES □ CONCUSSIONS □ TORN MUSCLES/LIGAMENTS □ OTHER

PLEASE DESCRIBE, INCLUDING DATE OF INJURY: _____

_____

_____

_____

_____

MOTOR VEHICLE CRASHES – DATE:	LOSS OF CONSCIOUSNESS?	HEAD TURNED AT IMPACT?	HOSPITALIZED?
_____	YES / NO	YES / NO	YES / NO
_____	YES / NO	YES / NO	YES / NO
_____	YES / NO	YES / NO	YES / NO
_____	YES / NO	YES / NO	YES / NO

VACCINATIONS: □ DIPHTHERIA/POLIO/TETANUS (DTAP/TDAP) □ MEASLES/MUMPS/RUBELLA (MMR) □ CHICKEN POX

□ SMALLPOX □ HEPATITIS A □ HEPATITIS B □ FLU □ HPV □ PNEUMOCOCCAL (PCV-7) □ POLIO □ HIB

□ MENINGOCOCCAL □ ROTAVIRUS □ HERPES ZOSTER □ H1N1 □ OPV/IPV □ HAV

□ OTHERS: _____

PAST HEALTH HISTORY

PAST SURGERIES/OPERATIONS	DATE	OUTCOME/COMPLICATIONS

MEDICATIONS: - DRUG NAME	DAILY AMOUNT	PURPOSE OF MEDICATION

DO YOU HAVE ANY MEDICATION ALLERGIES? □ NO □ YES, PLEASE LIST: _____

SUPPLEMENTS: - TYPE	DAILY AMOUNT	PURPOSE OF SUPPLEMENT

FAMILY HEALTH HISTORY: MOTHER: _____

FATHER: _____

BROTHERS/SISTERS: _____

MATERNAL GRANDPARENTS: _____

PATERNAL GRANDPARENTS: _____

OTHER RELATIVES: _____

Social Activities & Nutritional History

Favorite Activities: _____

_____

_____

Sleep (hours/night): _____ **Position:** ☐ Back ☐ Side ☐ Stomach ☐ Other: _____

Tobacco use: ☐ Smoking ☐ Chewing ☐ E-Cigs **How often?** ☐ Every Day ☐ Occasional ☐ Former ☐ Never

How often do you consume the following beverages and foods?

	Never	Occasionally	Regularly
Soda	☐	☐	☐
Diet soda	☐	☐	☐
Fruit juices	☐	☐	☐
Coffee/tea	☐	☐	☐
Energy drinks	☐	☐	☐
Alcoholic beverages	☐	☐	☐
Dairy products	☐	☐	☐
Soy (milk, tofu, etc)	☐	☐	☐
Fresh fruits & vegetables	☐	☐	☐

On average, how many glasses of water do you drink each day? _____

Do you use artificial sweeteners (such as Splenda, NutriSweet, sucralose, etc.)? ☐ Yes ☐ No

What are your favorite foods? _____

_____

_____

_____

_____

WOMEN'S HEALTH (FEMALES ONLY)

ALL INFORMATION YOU CHOOSE TO PROVIDE IN THIS SECTION IS KEPT CONFIDENTIAL.
OUR GOAL IN LEARNING MORE ABOUT YOUR HEALTH IS ALWAYS ONLY TO SERVE YOU BETTER.

ONSET OF MENSES: □ NOT YET **MONTH** _____ **YEAR:** _____ **AGE AT ONSET:** _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING? □ AMENORRHEA □ MENSTRUAL IRREGULARITY □ MENSTRUAL CRAMPING

NUMBER OF PREGNANCIES: (PLEASE INCLUDE DATES) _____

_____

_____

ANY COMPLICATIONS? (IF YES, PLEASE DESCRIBE) _____

_____

ONSET OF MENOPAUSE: □ NOT YET **MONTH** _____ **YEAR:** _____ **AGE AT ONSET:** _____

Goals and Expectations of Care

The purpose of this section is to help us understand more about what you want to achieve during your time in our clinic, and your long-term health goals. Answering these questions honestly will assist us in ensuring that we meet or exceed all of your expectations, and address all your concerns to your satisfaction.

Please number the THREE most important goals you'd like to achieve from your treatment: (1 = most important)

____ Having Better Body Symmetry	____ Getting Out of Pain	____ Better Balance
____ Improving My Body's Ability to Exercise	____ Reducing the Cobb Angle	____ Stop Progression
____ Preventing Long-term Disability	____ Avoiding Surgery	____ Avoiding Bracing

____ Other (please describe): _____

_____

Which of the following best summarizes your feelings regarding x-rays? (mark only one)

_____ I am concerned about x-ray radiation and want as few x-rays as possible, even if this reduces the doctor's ability to provide the best possible treatment.

_____ I would like the doctor to utilize their best judgment to take as few x-rays as possible, without making it harder for them to treat my scoliosis.

_____ I do not have any strong feelings about x-rays.

_____ I would like the doctor to utilize their best judgement in taking x-rays to ensure I receive the best possible results from treatment. I am concerned about x-ray radiation, but more concerned about the scoliosis.

_____ I am not concerned about x-ray radiation. I believe the risk of cancer from today's x-ray technologies is minimal, and the valuable information gained from x-rays is worth the small amount of radiation exposure.

Please use the space below to share any thoughts, questions, or concerns you may have at this time:

_____

_____

_____

_____

_____

_____

_____

_____

_____

INFORMED CONSENT

REGARDING: CHIROPRACTIC ADJUSTMENTS, EXAMS, MODALITIES, AND THERAPEUTIC PROCEDURES

I HAVE BEEN ADVISED THAT CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, HOLDS CERTAIN RISKS. WHILE THE RISK ARE MOST OFTEN VERY MINIMAL, IN RARE CASES, COMPLICATIONS SUCH AS SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND ALTHOUGH RARE, MINOR FRACTURES, AND POSSIBLE STROKE (WHICH OCCURS AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION) HAVE BEEN ASSOCIATED WITH CHIROPRACTIC ADJUSTMENTS. TREATMENT OBJECTIVES AS WELL AS THE RISKS ASSOCIATED WITH CHIROPRACTIC ADJUSTMENTS AND, ALL OTHER PROCEDURES PROVIDED AT JUSTIN DICK PLLCHAVE BEEN EXPLAINED TO ME TO MY SATISFACTION AND I HAVE CONVEYED MY UNDERSTANDING OF BOTH TO THE DOCTOR. AFTER CAREFUL CONSIDERATION, I DO HEREBY CONSENT TO TREATMENT BY ANY MEANS, METHOD, AND OR TECHNIQUES, THE DOCTOR DEEMS NECESSARY TO TREAT MY CONDITION AT ANY TIME THROUGHOUT THE ENTIRE CLINICAL COURSE OF MY CARE.

REGARDING: CHIROPRACTIC SCOLIOSIS TREATMENT (ADJUSTMENTS, EXAMS, MODALITIES, AND THERAPEUTIC PROCEDURES)

I HAVE BEEN ADVISED OF THE ABOVE AS WELL AS THE STANDARDS ASSOCIATED WITH SCOLIOSIS TREATMENT IN REGARDS TO WATCHING AND WAITING, BRACING AND SURGERY. I HAVE ALSO BEEN INFORMED OF THE RISKS ASSOCIATED WITH NOT FOLLOWING THOSE STANDARDS. I AM ALSO AWARE THAT THERE IS NO GUARANTEE OR PROMISE OF ANY RESULTS AND I AM AWARE THAT THE SCOLIOSIS CAN STILL PROGRESS. I ALSO UNDERSTAND THAT A LACK OF COMPLIANCE WITH MY DOCTOR'S RECOMMENDATIONS REGARDING THE TREATMENT SCHEDULE AND CLINIC AND HOME THERAPIES MAY RESULT IN A NEGATIVE OUTCOME.

AFTER CAREFUL CONSIDERATION, I DO HEREBY CONSENT TO TREATMENT BY ANY MEANS, METHOD, AND OR TECHNIQUES THAT THE DOCTOR DEEMS NECESSARY TO TREAT MY CONDITION AT ANY TIME THROUGHOUT THE ENTIRE CLINICAL COURSE OF MY CARE AND UNDER MY FREE WILL CHOOSE NOT TO FOLLOW THE STANDARDS ASSOCIATED WITH SCOLIOSIS TREATMENT.

_____ ____/____/_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE** **WITNESS INITIALS_____**

REGARDING: X-RAYS/IMAGING STUDIES
FEMALES ONLY

PLEASE READ CAREFULLY AND CHECK THE BOXES, INCLUDE THE APPROPRIATE DATE, THEN SIGN BELOW IF YOU UNDERSTAND AND HAVE NO FURTHER QUESTIONS, OTHERWISE SEE OUR RECEPTIONIST FOR FURTHER EXPLANATION.

THE FIRST DAY OF MY LAST MENSTRUAL CYCLE WAS ON _____ - _____ - _____ (DATE)

I HAVE BEEN PROVIDED A FULL EXPLANATION OF WHEN I AM MOST LIKELY TO BECOME PREGNANT, AND TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT.

BY MY SIGNATURE BELOW I AM ACKNOWLEDGING THAT THE DOCTOR AND OR A MEMBER OF THE STAFF HAS DISCUSSED WITH ME THE HAZARDOUS EFFECTS OF IONIZATION TO AN UNBORN CHILD, AND I HAVE CONVEYED MY UNDERSTANDING OF THE RISKS ASSOCIATED WITH EXPOSURE TO X-RAYS. AFTER CAREFUL CONSIDERATION I THEREFORE, DO HEREBY CONSENT TO HAVE THE DIAGNOSTIC X-RAY EXAMINATION THE DOCTOR HAS DEEMED NECESSARY IN MY CASE.

_____ ____/____/_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE** **WITNESS INITIALS_____**

CONSENT FOR CHIROPRACTIC TREATMENT OF A MINOR CHILD

I, _____, THE □ MOTHER □ FATHER □ LEGAL GUARDIAN OF _____, HEREBY CONSENT TO THE RENDERING OF CARE, INCLUDING DIAGNOSTIC PROCEDURES, X-RAYS, AND TREATMENT GIVEN BY THE JUSTIN DICK PLLC,

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL REASONABLE CHARGES IN CONNECTION WITH CARE AND TREATMENT RENDERED. I HAVE READ THIS FORM AND CERTIFY THAT I UNDERSTAND ITS CONTENTS.

SIGNATURE: _____ DATE: _____

WITNESS NAME: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Patient Financial Responsibility Notice

Thank you for choosing the Justin Dick PLLC your chiropractic healthcare provider! We are honored by your choice and are committed to providing you with the highest quality chiropractic care. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

Patient Financial Responsibilities:

- The patient (or legal guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by submitting the billing to your insurance. However, the Justin Dick PLLC is not part of any insurance networks and therefore would fall under out-of-network coverages. We recommend that you contact your insurance company and ask them what your coverage is for Out-of-Network (Non-Provider) Chiropractic services. We can provide you with the treatment codes that your insurance company will need.
- The patient is required to provide us with the most current and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not accurate or current.
- Payment is due in full at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur and be responsible for the payment of additional charges at the discretion of Justin Dick PLLC. These charges include (but are not limited to):
    - Charge for returned checks
    - Charge for missed appointments without 24 hours' advance notice. Cancellation of Intensive Care appointments without 72 hours' advance notice will result in a cancellation fee of $300
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, and/or advice
    - Charge for the copying and distribution of patient medical records and/or x-rays
    - Charge for the completion of lengthy forms by the doctor or staff
    - Any costs associated with collection of past-due balances and interest fees

(continued on next page)

Patient Financial Responsibility Notice (continued)

Patient Authorizations

- By my signature below, I hereby authorize the Justin Dick PLLC and the associated doctors and staff to release records and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other doctors or healthcare entities required to participate in my care.
- By my signature below, I understand that I am financially responsible for charges not covered by my insurance company or other third-party payers. If I discontinue treatment, I understand and agree that any remaining balance on my account will be due immediately.
- By my signature below, I authorize the doctors and staff of the Justin Dick PLLC to communicate with me by mail, answering machine messages, e-mail, and/or text messages according to my preferences and the information I have provided in my patient registration.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

Patient Name: _____

Signature of Parent or Guardian: _____ **Date:** _____

Justin Dick PLLC
Phone: 704-947-2902
Address: 10215 Hickorywood Hill Avenue, Suite A, Huntersville, NC 28078

E-mail: Scoliosis@truehealthcharlotte.com

NOTICE OF PRIVACY PRACTICES
Justin Dick PLLC
Effective Date: September 23, 2013

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

This Notice of Privacy 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 PHI. "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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the 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.

YOUR HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in HER software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor,

POSTAGE, AND SUPPLIES ASSOCIATED WITH YOUR REQUEST. WE MAY NOT CHARGE YOU A FEE IF YOU REQUIRE YOUR MEDICAL INFORMATION FOR A CLAIM FOR BENEFITS UNDER THE SOCIAL SECURITY ACT OR ANY OTHER STATE OR FEDERAL NEEDS-BASED BENEFIT PROGRAM. IF YOUR MEDICAL INFORMATION IS MAINTAINED IN AN ELECTRONIC HEALTH RECORD, YOU ALSO HAVE THE RIGHT TO REQUEST THAT AN ELECTRONIC COPY OF YOUR RECORD BE SENT TO YOU OR TO ANOTHER INDIVIDUAL OR ENTITY. WE MAY CHARGE YOU A REASONABLE COST BASED FEE LIMITED TO THE LABOR COSTS ASSOCIATED WITH TRANSMITTING THE ELECTRONIC HEALTH RECORD. YOU HAVE A RIGHT TO HAVE THIS INFORMATION WITH-IN 30 DAYS OF RECEIPT OF YOUR REQUEST.

RIGHT TO AMEND: LF YOU FEEL THAT MEDICAL INFORMATION WE HAVE ABOUT YOU IS INCORRECT OR INCOMPLETE, YOU MAY ASK US TO AMEND THE INFORMATION. YOU HAVE THE RIGHT TO REQUEST AN AMENDMENT FOR AS LONG AS WE RETAIN THE INFORMATION. TO REQUEST AN AMENDMENT, YOUR REQUEST MUST BE MADE IN WRITING AND SUBMITTED TO OUR PRIVACY OFFICER. IN ADDITION, YOU MUST PROVIDE A REASON THAT SUPPORTS YOUR REQUEST. WE MAY DENY YOUR REQUEST FOR AN AMENDMENT IF IT IS NOT IN WRITING OR DOES NOT INCLUDE A REASON TO SUPPORT THE REQUEST. IN ADDITION, WE MAY DENY YOUR REQUEST IF YOU ASK US TO AMEND INFORMATION THAT: • WAS NOT CREATED BY US, UNLESS THE PERSON OF ENTITY THAT CREATED THE INFORMATION IS NO LONGER AVAILABLE TO MAKE THE AMENDMENT; • IS NOT PART OF THE MEDICAL INFORMATION KEPT BY OR FOR JUSTIN DICK PLLC. • IS NOT PART OF THE INFORMATION WHICH YOU WOULD BE PERMITTED TO INSPECT AND COPY; OR • IS ACCURATE AND COMPLETE. IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU MAY SUBMIT A STATEMENT OF DISAGREEMENT. WE MAY REASONABLY LIMIT THE LENGTH OF THIS STATEMENT. YOUR LETTER OF DISAGREEMENT WILL BE INCLUDED IN YOUR MEDICAL RECORD, BUT WE MAY ALSO INCLUDE A REBUTTAL STATEMENT.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION MADE BY US. IN YOUR ACCOUNTING, WE ARE NOT REQUIRED TO LIST CERTAIN DISCLOSURES, INCLUDING: • DISCLOSURES MADE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PURPOSES OR DISCLOSURES MADE INCIDENTAL TO TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, HOWEVER, IF THE DISCLOSURES WERE MADE THROUGH AN ELECTRONIC HEALTH RECORD, YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING FOR SUCH DISCLOSURES THAT WERE MADE DURING THE PREVIOUS 3 YEARS; • DISCLOSURES MADE PURSUANT TO YOUR AUTHORIZATION; • DISCLOSURES MADE TO CREATE A LIMITED DATA SET • DISCLOSURES MADE DIRECTLY TO YOU. TO REQUEST AN ACCOUNTING OF DISCLOSURES, YOU MUST SUBMIT YOUR REQUEST IN WRITING TO OUR PRIVACY OFFICER. YOUR REQUEST MUST STATE A TIME PERIOD WHICH MAY NOT BE LONGER THAN SIX YEARS AND MAY NOT INCLUDE DATES BEFORE APRIL 14, 2003. YOUR REQUEST SHOULD INDICATE IN WHAT FORM YOU WOULD LIKE THE ACCOUNTING OF DISCLOSURES (FOR EXAMPLE, ON PAPER OR ELECTRONICALLY BY EMAIL). THE FIRST ACCOUNTING OF DISCLOSURES YOU REQUEST WITHIN ANY 12 MONTH PERIOD WILL BE FREE. FOR ADDITIONAL REQUESTS WITHIN THE SAME PERIOD, WE MAY CHARGE YOU FOR THE REASONABLE COSTS OF PROVIDING THE ACCOUNTING OF DISCLOSURES. WE WILL NOTIFY YOU OF THE COSTS INVOLVED AND YOU MAY CHOOSE TO WITHDRAW OR MODIFY YOUR REQUEST AT THAT TIME, BEFORE ANY COSTS ARE INCURRED. UNDER LIMITED CIRCUMSTANCES MANDATED BY FEDERAL AND STATE LAW, WE MAY TEMPORARILY DENY YOUR REQUEST FOR AN ACCOUNTING OF DISCLOSURES.

RIGHT TO REQUEST RESTRICTIONS: YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OR LIMITATION ON THE MEDICAL INFORMATION WE USE OR DISCLOSE ABOUT YOU FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOU ALSO HAVE THE RIGHT TO REQUEST A LIMIT ON THE MEDICAL INFORMATION WE COMMUNICATE ABOUT YOU TO SOMEONE WHO IS INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE OR THE PAYMENT FOR YOUR CARE. YOU HAVE A RIGHT TO RESTRICT CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION TO A HEALTH PLAN WHERE YOU HAVE PAID OUT OF POCKET IN FULL FOR THE HEALTHCARE ITEM OR SERVICE. AS NOTED ABOVE, WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. IF WE DO AGREE, WE WILL COMPLY WITH YOUR REQUEST UNLESS THE RESTRICTED INFORMATION IS NEEDED TO PROVIDE YOU WITH EMERGENCY TREATMENT. TO REQUEST RESTRICTIONS, YOU MUST MAKE YOUR REQUEST IN WRITING TO OUR PRIVACY OFFICER. LN YOUR REQUEST, YOU MUST TELL US WHAT INFORMATION YOU WANT TO LIMIT, WHETHER YOU WANT TO LIMIT OUR USE, DISCLOSURE, OR BOTH AND TO WHOM YOU WANT THE LIMITS TO APPLY.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU ABOUT MEDICAL MATTERS IN A CERTAIN WAY OR AT A CERTAIN LOCATION. FOR EXAMPLE, YOU CAN ASK THAT WE ONLY CONTACT YOU AT WORK OR BY E-MAIL. TO REQUEST CONFIDENTIAL COMMUNICATIONS, YOU MUST MAKE YOUR REQUEST IN WRITING TO OUR PRIVACY OFFICER. WE WILL ACCOMMODATE ALL REASONABLE REQUESTS.

RIGHT TO RECEIVE NOTICE OF A BREACH: WE ARE REQUIRED TO NOTIFY YOU BY FIRST CLASS MAIL OR BY EMAIL (IF YOU HAVE INDICATED A PREFERENCE TO RECEIVE INFORMATION BY E-MAIL), OF ANY BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION AS SOON AS POSSIBLE, BUT IN ANY EVENT, NO LATER THAN 60 DAYS FOLLOWING THE DISCOVERY OF THE BREACH. "UNSECURED PROTECTED HEALTH INFORMATION" IS INFORMATION THAT IS NOT SECURED THROUGH THE USE OF A TECHNOLOGY OR METHODOLOGY IDENTIFIED BY THE

Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Justin Dick. If you would like further information about our privacy policies and practices please contact Dr. Justin Dick.

This clinic has an open door adjusting area. If you require privacy, it will be provided if your request is in writing. This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

This notice is effective as of April 14th, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I received a copy of this notice.

Signature: _____ Date: _____

Print Name: _____

Justin Dick PLLC
Phone: 704-947-2902
Address: 10215 Hickorywood Hill Avenue, Suite A, Huntersville, NC 28078

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

TO: _____

_____

_____

ATTENTION: _____

THIS AUTHORIZATION IS BEING REQUESTED FOR CLINICAL CARE REGARDING THE FOLLOWING PATIENT:

NAME: _____

SIGNATURE: _____

BIRTHDATE: _____ SOCIAL SECURITY # (OPTIONAL) _____

DATES OF SERVICE: _____

THE FOLLOWING INFORMATION SHOULD BE RELEASED TO THE JUSTIN DICK PLLC.
TO THE ADDRESS, FAX NUMBER, AND/OR E-MAIL ADDRESS ABOVE:

( ) OFFICE NOTES, REPORTS, AND RECORDS
( ) MRI AND / OR X-RAY REPORTS
( ) X-RAY FILMS
( ) OTHER: _____

NOTE: ONCE AGREED TO, THE PATIENT HAS THE RIGHT TO REVOKE THIS AUTHORIZATION AS IS DEEMED NECESSARY. YOUR CARE IN THIS CLINIC WILL NOT BE DEEMED CONDITIONAL ON AGREEING TO THIS AUTHORIZATION. THE INFORMATION RELEASED UNDER THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PARTY RECEIVING THE INFORMATION; WE HAVE NO CONTROL OVER SUCH REDISCLOSURES. UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION SHALL EXPIRE UPON THE REQUEST OF YOU (THE PATIENT) OR YOUR PERSONAL REPRESENTATIVE.