Work-Injury History Questionnaire **Date of Injury:** _____

Dear Patient: You can write in any of the blank areas. It is okay to circle and check items. Feel **free to use any blank space to answer these questions.**

Name: _____ DOB: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status ( )single ( )married ( )divorced ( )widowed Spouse's name: _____

Emergency contact: _____ Phone: _____

Name of Compensation Carrier: _____ Phone: _____

Address of Carrier: _____ City: _____ State: _____ Zip: _____

Occupation, and for how long? _____

Employer's Name: _____ Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

How do you spend much of your workday? Feel free to write percentages or indicate what you do the most and least.

Standing Sitting Walking Carrying Working Overhead Stooping Reaching Kneeling Driving

Climbing Repetitive Hand Motion Repetitive Foot Motion Sitting in Heavy Machinery Push-Pull Lifting

Were there any poor working conditions (e.g. slippery, poor Fighting, chemical fumes, etc.): No Yes

Did you feel any pain immediately after the accident? No Yes If "Yes" where?

Did you feel any pain later on after the accident? No Yes When and Where?

How soon did you return to work alter the accident? _____ Hours, _____ days, or ( )did not return to work.

If you did return to work, are you working: ( ) light duty ( ) partial hours ( ) restricted tasks ( ) other restrictions.

If you did not return to work, how much work time have you lost?

What doctors, specialists, or therapists have you consulted so far for this injury (name/specialty)?

Have you ever had a Workers' Compensation claim before? No Yes.

Have you ever injured this body region previously (for any reason) or had any problems in the same areas before? No Yes

Prior to this injury, did any other diseases, accidents, or health problems affect your employment? No Yes

Prior to this injury, did you have to favor any part of your body in order to work? No Yes

Prior to this injury, were you capable of working on an equal basis with others your age' No Yes

Do you have a history of absenteeism from your job for any reasons? No Yes:

Since this injury are your symptoms: ( ) Improving? ( ) Getting Worse? ( ) The Same? ( ) Changing in Character or Location?

List Each Area Of Pain Or Complaint Separately.

1. Area of Pain:_____

The pain is... ☐ Constant ☐ Comes & goes; lasting for _____ ☐ minute(s) ☐ hour(s) ☐ day(s) ☐ week(s)

In general symptoms are better in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general symptoms are worse in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general is pain constant and unrelated to movement? ☐ Yes ☐ No Does this pain wake you up from sleep? ☐ Yes ☐ No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense pain imaginable

The pain is aggravated by:_____

The pain is relieved by:_____

2. Area of Pain:_____

The pain is... ☐ Constant ☐ Comes & goes; lasting for _____ ☐ minute(s) ☐ hour(s) ☐ day(s) ☐ week(s)

In general symptoms are better in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general symptoms are worse in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general is pain constant and unrelated to movement? ☐ Yes ☐ No Does this pain wake you up from sleep? ☐ Yes ☐ No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense pain imaginable

The pain is aggravated by:_____

The pain is relieved by:_____

3. Area of Pain:_____

The pain is... ☐ Constant ☐ Comes & goes; lasting for _____ ☐ minute(s) ☐ hour(s) ☐ day(s) ☐ week(s)

In general symptoms are better in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general symptoms are worse in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general is pain constant and unrelated to movement? ☐ Yes ☐ No Does this pain wake you up from sleep? ☐ Yes ☐ No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense pain imaginable

The pain is aggravated by:_____

The pain is relieved by:_____

4. Area of Pain:_____

The pain is... ☐ Constant ☐ Comes & goes; lasting for _____ ☐ minute(s) ☐ hour(s) ☐ day(s) ☐ week(s)

In general symptoms are better in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general symptoms are worse in: ☐ AM ☐ Midday ☐ PM ☐ Symptoms do not change with time of day.
In general is pain constant and unrelated to movement? ☐ Yes ☐ No Does this pain wake you up from sleep? ☐ Yes ☐ No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense pain imaginable

The pain is aggravated by:_____

The pain is relieved by:_____

Past Medical History:

Check the boxes below if you've ever been medically treated for, been diagnosed with, or had significant medical problems with any of the following conditions **in the past**:

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Numbness/Tingling
- ☐ Sciatica
- ☐ Jaw Pain/TMJ
- ☐ Headaches
- ☐ Shoulder Pain
- ☐ Elbow/Arm Pain
- ☐ Knee/Leg Pain
- ☐ Foot or Ankle Pain
- ☐ Sprained Ankles
- ☐ Tendonitis/Bursitis
- ☐ Concussion
- ☐ Struck Unconscious
- ☐ Eye Injuries
- ☐ Sinus Problems
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Chest Pains
- ☐ High Blood Pressure
- ☐ Arteriosclerosis
- ☐ Constipation
- ☐ Sleep Disorder
- ☐ Fractures
- ☐ Irritable Bowel
- ☐ Digestion Problems
- ☐ Heart Problem
- ☐ Kidney Problem
- ☐ Thyroid Problem
- ☐ Liver Problem
- ☐ Gall Bladder Problem
- ☐ Lung Disease
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Prostate Problem
- ☐ Uterus/Ovary Prob's
- ☐ HIV +
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Anemia
- ☐ Excessive Thirst
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Frequent Urination
- ☐ Diabetes
- ☐ Limb Edema
- ☐ Bruise Easily
- ☐ Chronic Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Anxiety
- ☐ Chemical Addiction
- ☐ Eating Disorder
- ☐ Allergies
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Cancer
- ☐ Lumps or Tumors
- ☐ Other:_____

Please list **any and all** hospitalizations, surgeries or major injuries you had in the past. Do you have any residual issues?

_____

_____

_____

List **all** medicines you currently take:

_____

_____

_____

Social History:

Do you smoke? ☐ No ☐ Yes How much ? _____
Do you consume alcohol? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never
Do you crave "sweets"? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never
Do you eat "fast" food? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never
Coffee/Caffeine per Day? _____ cups/cans

Family History:

Mother:
Father:
Siblings:
_____

Do you have a regular exercise program? ☐ No ☐ Yes If yes, what and how often?

_____

List any hobbies or sports you participate in:

_____

Did you play any sports when you were younger? Which ones?

_____

Patient Signature:_____ ***Date:***_____

Today's Date: _____ Patient: _____ File: _____

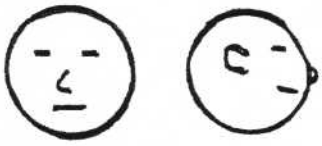
CIRCLE, MARK, COLOR-IN OR IDENTIFY AREAS OF YOUR BODY THAT HAVE A PROBLEM.

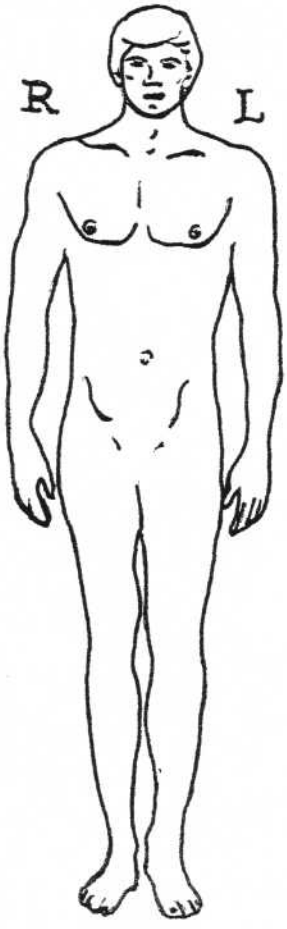
Feel free to use the symbols in the box below to describe the type(s) of pain or sensations you experience.

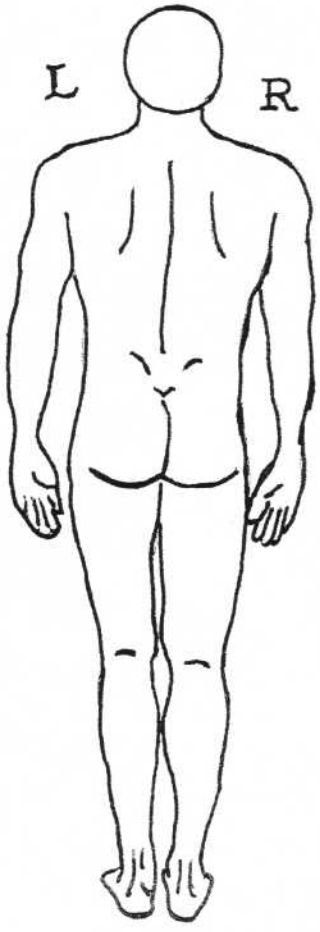
>>>	**Aching Pain**
XXX	**Burning Pain**
===	**Numbness**
OOO	**Pins & Needles**
////	**Stabbing Pain**

FOR FACE OR HEAD PAIN:

☐Rt Side ☐Lt Side ☐ Both







State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaracion o representacion material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensacion a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

CHIROPRACTIC

Workers' Compensation Financial Agreement

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available to you for your work related injury or illness. This form has been created to clearly communicate your financial responsibilities for the care you receive in our office.

Payment Arrangements

Because you are being treated for a work related condition, we would like for you to understand how your case will be handled by our office. The insurance carrier for your employer is fully responsible for payment of your care in our office. When a person is treated for a condition that is solely the result of an industrial accident or employment related incident, your worker's compensation insurance will pay for treatment that has been pre-authorized based on medical necessity.

Treatment Guidelines

There is specific treatment guidelines outlined in the ACOEM guidelines that all doctors treating patients for work injuries have to follow. We will prepare all the necessary reports, pre-authorization requests and claims on your behalf and submit them to your employer's insurance carrier for pre-authorization and payment. The insurance carrier has five working days to respond to our pre-authorization requests but often times they are behind schedule and it may take longer. We are diligent with our procedures and follow-up with the insurance companies, however, we can not guarantee that the workers' compensation carrier will accept our claims and/or recommendations for care. In addition, 2004 and 2005 injuries have a 24 visit max on physical medicine services (chiropractic, physical therapy, etc.).

Your Responsibilities

When you have suffered a work related injury or illness, the law requires that you notify your employer immediately after your injury occurs. If you do not report your injury as required, the Workers' Compensation carrier may deny your injury claim.

It is very important for you to follow our treatment recommendations and to keep your scheduled appointments in order to achieve maximum benefit for your condition and to follow the ACOEM guidelines as outlined in the California Workers' Compensation Labor Law. We will need to perform periodic re-examinations and assessment questionnaires to document the extent of your injuries, progress and to seek authorization for any treatment. The California Workers' Compensation Labor Law states that if you choose not to receive the care that is necessary for treatment of your condition, your Workers' Compensation benefits will be discontinued and your case will be closed.

Please be advised that if the Workers' Compensation carrier decides to completely deny your case and/or treatment that you are fully responsible for any outstanding balance on your account for services rendered.

Conclusion of Care

When your condition has reached 'pre-injury status' and/or stabilized we will notify your Workers' Compensation carrier and close your case. At that time, if you would like to continue receiving chiropractic care there are several affordable financial arrangements that can be made.

We thank you for the opportunity to serve you. If you have any questions regarding your case please do not hesitate to speak with us about your concerns.

I have read and fully understand and agree to the above.

_____ _____

Patient's Signature Date

CHIROMEDICA

Chiropractic Clinic

HIPAA NOTIFICATION

Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Chiromedica is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice on paper.

If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below. If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it.

Acknowledgement
I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

OR

Waiver
I, the undersigned, am aware of my right to receive a paper copy of the above Notice and I have declined such Notice. I am aware that this Notice is available to me from Chiromedica at any time. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

THE INJURED WORKER

Rights to Workers' Compensation Benefits and How to Obtain Them

Department of Industrial Relations
Division of Workers' Compensation

The information in this pamphlet is true in most situations. However some rules, exceptions, and deadlines not covered here may apply to you and affect your case. To learn more, see the factsheet For More Information. The information here describes the California workers' compensation system as of January 1998. It applies to most private, state, and local government employees whose idate of injuryi is 1994 or later.

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

This pamphlet has been approved by the Administrative Director of the Division of Workers' Compensation and complies with the requirements of Labor Code ß138.4, ß139.6, ß3553, and ß5401 and Title 8, California Code of Regulations ß9880 and ß9882. It is based, in large part, on work performed by the Labor Occupational Health Program, University of California at Berkeley, under contract with the Commission on Health & Safety and Workers' Compensation.

What Is Workers' Compensation?

If you get an injury or illness on the job, your employer is required by law to provide workers' compensation benefits. You could get hurt by:

- One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries. It may include injuries, including psychiatric injuries, resulting from a workplace crime.

  -or-

- Repeated exposures at work. Examples: hurting your wrist from doing the same motion over and over, losing your hearing because of constant loud noise.

What Are The Benefits?

Workers' compensation benefits can include:

Medical Care. Paid by your employer, to help you recover from an injury or illness caused by work. You should never receive a medical bill.

Temporary Disability Benefits. Payments if you lose wages because you can't do your usual job while recovering. As a general rule, you are paid two-thirds of the gross (pre-tax) wages you lose after your third day off work while recovering from an injury. However, you cannot receive more than the maximum weekly amount set by law. (See Table on page 5 for maximum benefit rates.) These temporary disability payments begin when your treating doctor says you can't do your usual work for more than three days, or you are hospitalized overnight. Payments must be made every two weeks, for as long as you are eligible.

Permanent Disability Benefits. Payments if your treating doctor says you will never recover completely and will always be somewhat limited in your ability to work. These payments are limited, and may not cover all your lost income. The number of weekly payments you will receive is determined by a permanent disability rating, based on (a) your medical condition, (b) your date of injury, (c) your age when injured, and (d) your occupation. Permanent disability benefit amounts are set by law. (See Table on page 5 for maximum benefit rates.) After the first

What are the Benefits
continued on page 2

What are the Benefits
continued from page 1

payment, permanent disability benefits must be paid every 14 days. They end when you reach the maximum amount allowed by law or when you settle your case and receive a lump sum.

Vocational Rehabilitation. Job placement counseling and possibly retraining, if you are unable to return to your old job and your employer doesn't offer other work. Vocational rehabilitation maintenance allowance benefits provide income support while you are participating in vocational rehabilitation. These payments are made every 14 days for as long as your are eligible. For injuries occurring on or after January 1, 1994, there is a $16,000 limit on all rehabilitation benefits. (See Table on page 5 for maximum benefit rates.)

Death Benefits. Payments to the spouse, children, or other dependents of a worker who dies from a job injury or illness. (See table on page 5 for maximum benefit rates) Death benefits must be paid every 14 days. A burial allowance is also paid.

More About Medical Care

Can I choose the doctor who will treat me? It depends. If you want to choose the doctor who will treat you for a job injury or illness, you must tell your employer the name and address of your personal physician before you are injured or become ill. You must do it in writing. This is called predesignating your personal physician. If you predesignate you will be allowed to see your personal physician right after you are injured or become ill. You may switch doctors later, if necessary. If you don't predesignate your employer usually will have the right to choose the doctor who

What Should I Do If Hurt On The Job?

If you are hurt on the job, you should:

- **Report The Injury To Your Employer.** Tell your supervisor right away. If your injury or illness developed gradually (like tendinitis or hearing loss), report it as soon as you learn it was caused by your job. Reporting promptly helps prevent problems and delays in receiving benefits, including medical care you may need to avoid further injury. If your employer does not learn of your injury within 30 days, you could lose your right to receive workers' compensation benefits.
- **Get Emergency Treatment** If Needed. If it's a medical emergency, go to an emergency room right away. Your employer may tell you where to go for treatment. Tell the health care provider who treats you that your injury or illness is job related.
- **Fill Out A Claim Form.** Your employer must give you a claim form within one working day after learning about your injury or illness. You use it to request workers' compensation benefits. Fill out and sign the employee portion of the claim form. Describe your injury completely. Include every part of your body affected by the injury. Give the form to your employer, which is called filing the claim form.
- **Get Good Medical Care.** Get good medical care to help you recover. You should be treated by a doctor who understands your particular type of injury or illness. Tell the doctor about your symptoms and the events at work that you believe caused them. Also, describe your job and your work environment.
- **What Happens After I File The Claim Form?** Your employer must fill out and sign the 'employer' portion of the claim form and give the completed form to a claims administrator. (This person handles claims for your employer and usually works for your employer's insurance company.) Your employer must give you a copy of the completed form within one working day after you filed it. Keep this copy. The claims administrator usually must decide within 90 days whether to accept or deny your claim.

treats you during the first 30 days after your employer learns about your injury or illness.

How do I predesignate? You can predesignate a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who treated you in the past and has your medical records. Or you can predesignate the office, clinic or hospital where the doctor treated you. (If you give your employer the name of your personal chiropractor in writing before you are injured, you may switch to this chiropractor upon request during the first 30 days.)

Notify your employer in writing. Your employer may give you a form to use. Make sure to include the following information:

1) Name of your employer.

2) Statement that if you are injured or become ill on the job, you designate your personal physician or personal physician's medical facility to provide medical care. Give the name, address, and phone number.

3) Your name.

4) Your signature.

5) Date.

Exceptions: Some employers have contracts with state-certified health care organizations (HCOs) to treat workers hurt on the job. If your employer has this kind of contract, there are different rules on choosing medical care. Your employer must give you written information about those rules.

- **Why is the choice of doctor important?** Your treating doctor will:

1) Decide what type of medical care you'll get.

2) Help identify the kinds of work you can do safely while recovering.

3) Determine when you can return to work.

4) Write medical reports that will affect the benefits you receive.

What Should I Do If There is a Dispute?

If you have a concern, speak up. See whether your employer or claims administrator can agree to resolve the problem. If this doesn't work, don't delay getting help. Try the following:

- Contact an Information & Assistance officer. State I & A officers answer questions and help injured workers. They may provide information and provide forms and help resolve problems with your claim. They hold workshops for injured workers. To contact or find a local office, check the Government Pages at the front of the white pages of your phone book. Look under: State Government Offices/ Industrial Relations/Workers' Compensation.

- Consult an Attorney. Lawyers who specialize in helping injured workers with their workers' compensation claims are called applicants' attorneys. Their job is to plan a strategy for your case, gather information to support your claim, keep track of deadlines, and represent you in hearings before a Referee (workers' compensation judge) of the Workers' Compensation Appeals Board. Most attorneys offer one free consultation. If you hire an attorney, the attorney's fees will be be taken out of benefits that you receive later. A Referee must approve the fee.

If you have a serious dispute that may require a decision by a workers' compensation referee (workers' compensation judge), an Application for Adjudication must be timely filed, normally within one year from the date of your injury or the last date you were paid benefits.

What Other Rights Do I Have?

It is illegal for your employer to punish or fire you for having a job injury, or for filing a workers' compensation claim when hurt on the job. The California Labor Code (section 132a) prohibits this kind of discrimination.

It's also illegal for your employer to discriminate against you because of a serious disability. The federal Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA) prohibit this. More information about ADA is available by calling the Equal Employment Opportunity Commission at 800-669-3362. Information about the state FEHA is available by calling 800-884-1684.

CHIROMEDICA

NOTICE OF PRIVACY PRACTICES

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Contact
We may contact you for appointment reminders
For Example:

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time and/or in the event that you miss your appointment we will call to re-schedule. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership
In the event that Chiromedica is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Chiromedica is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Chiromedica amend your protected health information. Please be advised that Chiromedica is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Chiromedica.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Chiromedica reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiromedica is required by law to comply with this Notice.

Chiromedica is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact: Angie Garza, Office Manager by calling the office at 415-567-2225. If Ms. Garza is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Chiromedica with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date