WELCOME

We would like to personally welcome you and your family to Innate Concepts Chiropractic and thank you for entrusting us with your health as well as the health of your family.

We are dedicated to serving you and your family to achieve all of your health goals through chiropractic. We know you may have many questions which we hope to answer today as well as during your next visit, the Report of Findings. If at any time, something remains unclear, please do not hesitate to ask.

The following forms are designed to help us be as efficient, yet as thorough as possible in evaluating the best course of care for you and your family. Please fill them out completely and ask for help if you have trouble understanding anything.

We look forward to helping you and your family enjoy a lifetime of health, happiness, and full expression of life with chiropractic care!

Yours in Health,

Dr. Mary Carleton and Dr. John Carleton

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

PATIENT INFORMATION

Name________________________________ Birth Date_____/_____/_____

Address________________ City___________ State____ Zip Code ____________

Social Security #_____-_____-_____ Home ( )__________ Work ( )___________

Fax ( )___________ Cell ( )____________ E-mail_______________

Occupation_____________ Employer_______________________________________

Employer's Address_____________________________ Employer's # _____________

Male___ Female___ Single___ Married___ Divorced___ Widowed___ # of Kids____

Name of Spouse______________ Name and Ages of Kids_______________________

Main Reason for consulting our office today____________________________________

Referred by_____________________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____________ ____________________ ____________

Signature Date

Payment is Expected at time of Service

I will be paying today by: Cash____ Check____ Credit Card____ Insurance_______

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed: _____________________ Date: _____________

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

HEALTH PROFILE

Childhood and Adolescence (Birth through age 17)

- □ Childhood Illnesses
- □ Vaccinations
- □ Sports
- □ Surgeries
- □ Heavy Backpack
- □ Auto Accidents
- □ Antibiotics/Inhalers
- □ Serious Falls
- □ Secondhand Smoke
- □ Caffeine/Artificial Sugar Intake
- □ Emotional Traumas
- □ Regular Chiropractic Care

Comments:____

Your Adulthood (Age 18- Present)

Physical Stress

- □ Slips or Falls
- □ Auto Accidents
- □ Sports Participation
- □ Sitting on Wallet
- □ Poor Sleeping Habits
- □ Sitting or Standing for Long Hours
- □ Carrying a Heavy Purse or Child
- □ Repetitive Lifting or Bending
- □ Broken Bones
- □ Surgery

Comments:____

Chemical Stress:

- □ Poor Diet
- □ Excessive Caffeine Intake
- □ Artificial Sugar Usage
- □ Smoking Cigarettes
- □ Environmental Pollutants
- □ Excessive Alcohol Intake
- □ Over the Counter Drugs
- □ Prescription Drugs

Comments:____

Emotional Stress:

□ Relationships
□ Money
□ Children
□ Illness or Loss of Loved One
□ Fast Past Life

□ Quick-Tempered
□ Verbal Abuse
□ Perfectionist
□ Procrastinator
□ Non-Expressive with Feelings

Comments:____

Health Habits

□ Do you get enough sleep?
□ Do you drink plenty of good water?
□ Do you exercise?
□ Are you taking any vitamins/supplements?

□ Do you relax and take vacations?
□ Are you committed to yourself?
□ Do you do yoga or get massages?
□ Do you eat healthy foods?

Comments:____

Family History: Do you have a blood relative with any of the following? Please list the relationship.

□ Thyroid Disease ______________
□ Tuberculosis ______________
□ Kidney Disease ______________
□ High Blood Press. ______________
□ Other ______________

□ Heart Disease ______________
□ Stroke ______________
□Musculoskeletal Dis. ______________
□Cancer ______________

Comments:____

INNATE CONCEPTS CHIROPRACTIC

Quality of Life Questionnaire

This questionnaire is designed to measure the degree to which several aspects of your life are **presently disrupted** by your health concern(s). We want to know how your health concern is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the **overall impact of your health concern on your life**, not just when it is at its worst. **Please circle the number which best describes your typical level of activities**. A "0" means you can perform all of your normal activities without any pain or regard to your health concern. A "10" means you can't perform any of those activities because of your pain or health concern.

1. **Family/Home Responsibilities**- This includes activities and chores around the house (ex. driving kids to school.)

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function Totally Unable to Function

2. **Recreation**- This includes hobbies, sports and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function Totally Unable to Function

3. **Social Activity**- This includes activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, dining out and other social functions.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function Totally Unable to Function

4. **Occupation**- This includes activities that are a part of or directly related to your job. This includes jobs such as that of a homemaker or a volunteer.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function Totally Unable to Function

5. **Self Care**- This includes activities which involve personal maintenance and independent daily living tasks (ex. taking a shower, driving, getting dressed.)

0 1 2 3 4 5 6 7 8 9 10
Totally Unable to Function

6. **Life- Support Activity**- This refers to basic life-supporting behaviors such as eating, sleeping and breathing.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function Totally Unable to Function

Name________________ Date____________ Total Score_____________

Since your health issue began, which change most accurately describes it?

□ About the same □ Getting Better □ Getting Worse □ Other_______________________

If you are experiencing pain or sensations, check all the boxes that describe it:

□ Sharp □ Dull □ Numb □ Tingling □ Stabbing □ Radiating □ Other___________

If you have pain, how would your rate it on a 1-10 scale? "0" is no pain.

0 1 2 3 4 5 6 7 8 9 10

How often are you experiencing this pain or sensation?

□ Intermittently (0-25%) □ Occasionally (26-50%) □ Frequently (51-75%) □ Constantly (76-100%)

Does your health issue interfere with any of the following?

□ Work □ Sleep □ Walking □ Sitting □ Hobbies □ Other__________________

Please list other Doctors you have seen for this health issue, and the length of time you were under their care.

□ Chiropractor ____

□ Other ____

Please check all symptoms or conditions you had or have, even if they do not seem relevant to your current health issue:

□ Past	□ Current	Pins/Needles Arm	□ Past	□ Current	Back Pain	□ Past	□ Current	Headaches
□ Past	□ Current	Pins/Needles Leg	□ Past	□ Current	Fainting	□ Past	□ Current	Dizziness
□ Past	□ Current	Numb Fingers	□ Past	□ Current	Loss of Taste	□ Past	□ Current	Fatigue
□ Past	□ Current	Numb Toes	□ Past	□ Current	Allergies	□ Past	□ Current	Depression
□ Past	□ Current	Mood Swings	□ Past	□ Current	Constipation	□ Past	□ Current	Fever
□ Past	□ Current	Sleeping Problems	□ Past	□ Current	Heart Disease	□ Past	□ Current	Cold Hands
□ Past	□ Current	Irregular/Painful Menses	□ Past	□ Current	Neck Pain	□ Past	□ Current	Cold Feet
□ Past	□ Current	Urinary Problems	□ Past	□ Current	Heartburn	□ Past	□ Current	Irritability
□ Past	□ Current	Loss of Balance	□ Past	□ Current	Upset Stomach	□ Past	□ Current	Diarrhea
□ Past	□ Current	Light Sensitive	□ Past	□ Current	Stiff Neck	□ Past	□ Current	Ulcers
□ Past	□ Current	Ringing in Ears	□ Past	□ Current	Hot Flashes	□ Past	□ Current	Tension
□ Past	□ Current	Loss of Smell	□ Past	□ Current	Chest Pain	□ Past	□ Current	Cancer
□ Past	□ Current	High Blood Pressure	□ Past	□ Current	HIV	□ Past	□ Current	Other

The information on this form is accurate to the best of my recollection and knowledge.

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

Patient Policies and Procedures

Sign In: Innate Concepts Chiropractic maintains a patient sign-in sheet located at the front desk. We ask when you arrive that you sign in by legibly printing your name. You will be called in the order you signed in for your Doctor.

Adjusting Rooms: Innate Concepts Chiropractic utilizes semi-private adjusting rooms, private exam rooms and a semi-private therapy room. If you would like to speak to your Doctor in private, please let your Doctor or a staff member know ahead of time.

Scheduling: To hold your preferred treatment time, we request that all your appointments be made in advance up to and including your re-exam. This will save you and the office time, eliminate waiting, and allow the doctor to be better prepared for your visit.

Missing or changing appointments: Keeping your appointments is very important to achieving the best results for your healthcare goals. If you need to change your appointment time or date, we ask that you call our office to reschedule. If you are calling to reschedule a massage we ask that you do so at least 24 hours in advance.

Upsets: We are here to serve you and your family. Please inform your doctor or a staff member about an upsetting matter should it arise. Our goal is to maintain a stress-free environment as well as satisfied patients.

Financial: Co-pays and co-insurance payment is due at the time of service. If a financial problem arises, please inform a staff member as soon as possible so it can be resolved. We do not want finances to ever be an issue during your course of care.

Family Care: It is our mission not only to help you achieve the best health possible but your family as well.

Hours:	Monday:	9am-1pm, 3-7pm
	Tuesday:	2pm-6pm
	Wednesday:	9am-1pm, 3-7pm
	Thursday:	Closed
	Friday:	9am-1pm, 3-6pm
	Saturday:	9a-12pm
	Sunday:	Closed

I, ____________________ have read and understand the above policies. I have received Innate Concepts Chiropractic's Privacy Notice and Disclosure to take home and read at my leisure.

_____________________ _____________ __________________

Patient Date Witness

INNATE CONCEPTS CHIRORPACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_________________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Innate Concepts Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for Innate Concepts Chiropractic to obtain payment for that treatment and to carry out its health care operations. Innate Concepts Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Innate Concepts Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. Innate Concepts Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by Innate Concepts Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. Innate Concepts Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Innate Concepts Chiropractic to treat me and obtain payment for that treatment, and as necessary for Innate Concepts Chiropractic to conduct its specific health care operations.

5. I understand that I have a right to request that Innate Concepts Chiropractic restricts how my PHI is used and/or disclosed to carry out treatment, payment and or health care operations. However, Innate Concepts Chiropractic is not required to agree to any restrictions that I have requested. If Innate Concepts Chiropractic agrees to a requested restriction, then the restriction is binding on Innate Concepts Chiropractic.

6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Innate Concepts has already taken action in reliance on the consent.

7. I understand that if I revoke this consent at any time, Innate Concepts Chiropractic has the right to refuse to treat me.

8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Innate Concepts Chiropractic will not treat me.

I HAVE READ AND UNDERSTAND THE FORGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

Patient's Name (Printed) ________________________

Patient's Signature ___________________________ Date ______________

Witness __________________________ Date________________

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

Terms of Acceptance

When a patient chooses chiropractic wellness care and we accept a patient for such care, it is essential for both to be working towards the same goal.

In order to achieve your chiropractic wellness goal, it is important for you to understand the terminology that will be used during your care. The following are some commonly used terms.

Adjustment: An adjustment is a specific, gentle force applied to the spent to remove nerve interference (i.e. subluxation) to allow the body to function at its optimal potential.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity; wholeness, in which all organs, tissues and cells are functioning at 100%.

Vertebral Subluxation: A bone out of alignment interfering w/ normal nerve flow from the brain to the rest of the body. This may lead to a state of "dis-ease" or lack of harmony within one's body.

Innate Intelligence: An inborn intelligence that enables the body to regulate and heal itself. It is present in each of us.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxations.

I, ________________________ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

______________________________ ________________

Signature Date

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

Financial Policy

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and, as such our patients must understand and agree to the following:

□ Commercial Health Insurance
You are considered a cash patient until this office qualifies and accepts your coverage. Our office does not guarantee that your insurance will pay. We will make every attempt to receive verification of your policy and what it covers. However, it must be understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance company. It is your responsibility to have an active role in the recovery of your claims. You are responsible to meet your deductible and co-insurance factors $______ and ______% as you go along, or at the end of each week. Patient's co-pay amount many not exceed $150.00 at any time.

□ Workman's Comp
If your condition is the result of a work related injury, we require that you have an authorization number and the name of the insurance adjustor; otherwise you will be required to pay for the initial visit in full at the time of service. If our worker's compensation case is contested, we require payment in full at the time of services, or confirmation of commercial health insurance coverage or other liable third party coverage. See above regarding commercial health insurance.

□ Auto Accidents/Personal Injury
If your condition is a result of an auto accident, we will bill your automobile med pay insurance. If med pay is not available, we may submit the claims to your personal health carrier. If third party liability cannot be confirmed, we will require payment in full at the time the services are rendered.

□ In the event you discontinue your program of care prior to doctor's consent, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.

I understand that I will receive a monthly bill reflecting the balance due. I understand that I am responsible to pay any and all remaining balances within 60 days from the date services are rendered. This office follows the guidelines of HIPPA regarding the setting of fees and copying records. I understand that if a balance is left unpaid for 60 days or more collection action will begin and the balance will then begin to accrue interest at a rate of 1.5% per month past 30 days. I also understand that if legal and/or collection services are required on a past due balance after sixty days from date of service, all costs including reasonable attorney fees are my responsibility or that of the legal guardian in the case of a minor.

If we accept assignment from your insurance company, or any liable third party, we maintain the right to demand payment from you, the patient, if for any reason your balance has not been paid in full within sixty days from the date of service.

I hereby authorize the release of any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me. I assign benefits to the provider for reimbursement of services, which have been incurred by Innate Concepts Chiropractic.

I understand and agree to the terms of this financial policy.

Signature:______________________________ Date:___________________

Witness:_______________________________ Date:___________________

INNATE CONCEPTS CHIROPRACTIC

668 E. Northwest Highway~Mount Prospect, IL 60056~847-577-2660

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Payment: We may have to disclose your examination, adjustment, and your payment records to another party, such as an HMO, a PPO, your employer, or a collection agency, if they are potentially responsible for the payment of your services.

Healthcare Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Your Authorization: There are certain circumstances under which we may use or disclose your medical information without first obtaining you Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies

information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that your or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.
Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays, records, or other similar forms of health information.

Directory/Sign-In Log: Innate Concepts Chiropractic maintains a directory of a sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to, others who are seeking care in the office.

Semi Private Adjusting Rooms and Therapy Suite: The practice maintains semi private adjusting rooms and therapy suite. Special concerns and circumstances regarding your condition may require a special consultation with the doctor in private. These should be arranged by notifying the receptionist.

Marketing/Fundraising: The practice produces newsletters as a means to help educate patients of chiropractic and other health care issues. This publication is voluntary and it is your option whether you would like to receive these mailings. The practice sponsors fundraising events to help raise donations for charities. Publications regarding these events may be promoted by mailings or phone calls informing patients of our events by our office staff. Innate Concepts Chiropractic does not receive compensation from any fundraising events or charities it sponsors. If you wish to be removed from our mailing list, please send notice in writing of said request.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We do not sell or disclose patient information to third party vendors.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages at home/work, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. The fee per copy is 5 cents for each page, $12 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

OUR DUTIES

We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information. We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. More information is available about complaints on-line at the government's website: http:www.hhs.gov/ocr/hippaa.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Effective Date: This notice is effective April 14, 2003 and applies to all protected health information contained in your medical records maintained by us.

Contact Officer:____

Telephone:____________________ Fax:______________________________

Address:____