ADVANCED CARE
CHIROPRACTIC CENTER

Patient Intake Form

Date _____

First Name _____

Last Name _____

DOB _____

Sex ◯ Male ◯ Female

SSN _____

Address _____

City _____

State _____

Zip Code _____

Phone 1 _____

◯ Home ◯ Mobile ◯ Work ◯ Other

Phone 2 _____

◯ Home ◯ Mobile ◯ Work ◯ Other

Fax _____

Email _____

Employer _____

Employer Phone _____

Occupation _____

Job Status

◯ Not Employed ◯ Employed

◯ Part-Time Student ◯ Retired

◯ Full-Time Student

Marital Status

◯ Single ◯ Married ◯ Other

Receive Appointment Reminders

◯ Declined ◯ Voice ◯ Text ◯ Email

Height ___ ' ___ "

Weight _____ lbs

Reason For Visit: ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury ◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other _____

Referred By: ◯ Provider ◯ Friend ◯ Family ◯ Other _____

Referred By Name _____

How Heard of Us: ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website ◯ Advertisement ◯ Other _____

Demographics

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or Other Specific Islander ◯ Other _____

Ethnicity: ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other _____

Dominance: ◯ Right ◯ Left ◯ Ambidextrous

Insurance Information

Primary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

$/Year _____ Visits/Year ____ Therapy Visits/Year ____

PCP Referral Required ◯ Yes ◯ No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Secondary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required ◯ Yes ◯ No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Emergency Contact Information

First Name _____ Relationship _____

Last Name _____ Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chronic Fatigue	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Asthma	☐ Emphysema	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Epilepsy	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Fibromyalgia	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Chemical Dependency	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Disorder	☐ Venereal Disease
☐ Chicken Pox	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: ◯ Intermittent ◯ Occasional ◯ Frequent ◯ Constant

_____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Duration: Lasting _____ ◯ Minutes ◯ Hours

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Slight ◯ Moderate ◯ Severe

Is your condition: ◯ Same ◯ Better ◯ Worse

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting ☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning ☐ twisting ☐ walking ☐ working

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching ☐ walking ☐ wraps

What daily activities are affected due to the problem? ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ going from laying down to sitting ☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting ☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

Daily Habits

Do you smoke? ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ no ◯ light ◯ moderate ◯ heavy

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations ☐ Persistent Coughing

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds

☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply ☐ None

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness

☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling

☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply ☐ None

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary tract infections

☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)

☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst

☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Vascular/Hematologic: Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply ☐ None

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female:

Are you pregnant? ◯ Yes ◯ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Male: Please check all that apply ☐ None

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

Family History

Family Member Name	Relationship	Status	Conditions

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____

Print Name of Patient, Parent, Guardian or Personal Representative

ADVANCED CARE
CHIROPRACTIC CENTER
1613 S. RIVERSIDE AVE. STE D, RIALTO, CA 92376 (PH) 909-820-2220 (FAX) 909-820-2224
WWW.ACCHIROCENTER.COM

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Thy K. Nguyen D.C. to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctors (group) such sums as may be due and owing them for medical services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctors (group) for all medical bills submitted by them for service rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctors of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctors' office. I have been advised that if my attorney does not wish to cooperate in protecting the doctors' interest, the doctor (group) will not await payment but may declare the entire balance due and payable.

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctors above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____ Attorney's Signature: _____

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Advanced Care Chiropractic Center
1613 S. Riverside Ave, Suite D
Rialto, CA 92376
FAX (909) 820-2224

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Thy K. Nguyen D.C. and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Thy Nguyen and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure, which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by patient's representative, if necessary, eg.,if patient is a minor or physcially or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Patient Representative

*As:*_____
Relationship or authority of Patient's Representative

_____
Date Signed

ADVANCED CARE
CHIROPRACTIC CENTER
1613 S. Riverside Ave. Ste D, Rialto, CA 92376 (Ph) 909-820-2220 (Fax) 909-820-2224
www.ACChiroCenter.com

MEDICAL RECORD RELEASE FORM

Telephone: 909-820-2220

Fax: 909-820-2224

E-mail: tknchiropractic@gmail.com

_____ _____

Patient Name *Date of Birth*

I hereby authorize the below listed entity to release medical information to the Thy K. Nguyen, DC Chiropractic:

Name: _____ *Telephone#:* _____

Address: _____ *Fax#:* _____

_____

Medical Information Requested:

- ☐ *All Records*
- ☐ *Specific Records from* _____ *to* _____
- ☐ *Immunizations & Physical Examinations*
- ☐ *Radiology Reports {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}*
- ☐ *Other* _____

_____ _____

Signature of Patient or Legal Guardian *Date*

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

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NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Advanced Care Chiropractic Center Inc.
1613 S. Riverside Ave.
Suite D
Rialto, CA 92376
Thynguyendc@gmail.com
909-820-2220

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment.

Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you

of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances,
we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate
or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

I have received or reviewed the privacy practice notice for Advanced Care Chiropractic Center, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print Name of Patient