Baertlein Chiropractic Initial Patient Intake Form

Dr. Krista Baertlein D.C.

Date_____

Patient Name_____

Date of Birth_____ Social Security #_____

Address_____

_____

_____

Home Phone#_____ work phone#_____

Employer_____

Insurance company_____

Subscriber ID_____ Group #_____

If Applicable

Marital Status_____

Spouses name_____

Date of Birth_____ Social Security #_____

Employer_____

Insurance company_____

Subscriber ID_____ Group #_____

Comprehensive Health & Wellness Questionnaire

Patient name _____ Birth date _____ Today's Date _____ Age ____

Conditions you would like the doctor to evaluate _____

Have you had these conditions evaluated before? *YES* *NO*

If yes, by whom and what did they find? _____

When did you first notice these symptoms? _____

Are these symptoms getting progressively worse? _____

Which symptoms are constant? _____

Which symptoms come & go? _____

Prior professional seen for this condition?
❑ MEDICAL DOCTOR
❑ CHIROPRACTOR
❑ PHYSICAL THERAPIST
❑ ACUPUNCTURIST
❑ MASSAGE THERAPIST
❑ OTHER _____

Do they interfere with	Symptoms worse in:	Painful/difficult activities?
❑ WORK	❑ MORNING	❑ WALKING
❑ SLEEP	❑ MIDDAY	❑ BENDING
❑ DAILY ROUTINE	❑ NIGHT	❑ LYING DOWN
❑ RECREATION	❑ COLD and/or RAINY WEATHER	❑ LIFTING ☐ SITTING

What happens? _____

Your occupation and primary physical duties: _____

Have you ever been to a chiropractor before? *YES* *NO* If Yes, for what symptoms: _____

Name of chiropractor(s) _____ Were the chiropractic treatments effective? *YES* *NO* How long ago? _____

Are you taking drugs for your current problem? *YES* *NO* Name of drugs: _____

Do you sleep on your: *BACK* *SIDE* *STOMACH* *ALL POSITIONS* Rate your bed's support: *FIRM* *GOOD* *FAIR* *POOR*

Type of pillow: *THICK* *MEDIUM* *THIN* *NONE* *CERVICAL PILLOW* Type of mattress: *WATERBED* *AIR* *SPRING*

Date of Last:	***Date of Last:***	***Date of Last:***	***Date of Last:***
Physical Exam _____ Doctor's Name _____ Routine? *YES* *NO* If not a routine physical, what was the Dr. looking for? ____ _____ _____	X-rays: _____ X-ray facility? _____ Of what body part? *NECK* *BACK* *HEAD* *ARM* *HAND* *CHEST* *HIP* *KNEE* *FOOT*	Blood Tests: _____ Urine Tests: _____ Ordered by Dr. _____ Routine? *YES* *NO* If not routine, what is your Dr. monitoring? _____ _____	Other tests ordered? *MRI* *CT Scan* *EKG/Stress test* EEG Other test(s) _____ _____ _____

Vitamins, minerals, herbs: (Please list any below that you may be taking)

_____

_____

_____

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Patient name:_____

The following sheets deal with your general health. As you will see, the list of questions is quite extensive and thorough. It is important to circle all those things that apply. Do not skim through. Providing complete and accurate information will aid the doctor in keying in on aspects of your health, diet, lifestyle or genetics that may be aggravating or predisposing factors in your health. Properly answering these questions may provide the doctor with clues that may improve chronic problems like weight control, fatigue, pains, arthritis, diabetes, high blood pressure, as well as a variety of other conditions

Fill in the blanks. Circle or check all that apply.

Current Age _____

Male Female

Drink soft drinks? YES NO If yes…

- ❑ less than once per week
- ❑ 1-3 drinks per week
- ❑ 1-2 drinks per day
- ❑ 3-5 drinks per day
- ❑ >5 drinks per day

REGULAR NUTRASWEET SPLENDA

Have you ever smoked? YES NO

If YES, how many years _____

Do you currently smoke? YES NO

Did you quit? NO YES When _____.

(current/past smokers circle one below)

- ❑ 1/2 pack/day
- ❑ 1 pack/day
- ❑ 2 or more packs/day
- ❑ Other _____

Alcohol consumption (if yes, check one below)

- ❑ less than once per week
- ❑ 1-3 drinks per week
- ❑ 1-2 drinks per day
- ❑ 3-5 drinks per day
- ❑ >5 drinks per day

I drink _____ cups of coffee per day.

❑ Need/like to drink coffee/soda to get started.

Current drugs use:

1. Use aspirin
2. Use acetaminophen (Tylenol)
3. Use Advil/Motrin/ibuprofen
4. Use Aleve/naproxen
5. Take a stool softener
6. Take daily fiber supplement
7. Taken antibiotics more than once (last 3 yrs)
8. Take high blood pressure drugs (name) _____
9. Take thyroid drugs (name) _____
10. Take heart drugs (name) _____
11. Take stomach acid/ulcer drugs (name) _____
12. Take blood thinner (name) _____
13. Take allergy drugs _____
14. Take birth control pills (name) _____
15. Take sleeping drugs (name) _____
16. Take anti-anxiety drugs (name) _____
17. Take cholesterol lowering drugs _____
18. Over-the-counter drugs not listed above (list) _____ _____ _____
19. Take multivitamin (name)

Past Drug History

20. Birth Control Pills Number of years ____
21. Anticonvulsant/antiseizure? ____

Surgeries/Medical Procedures

22. Adenoids removed
23. Cataract surgery
24. Neck surgery
25. Angioplasty
26. Gall bladder removed
27. Pacemaker implanted
28. Appendectomy
29. Hiatal hernia
30. Reconstructive surgery
31. Back surgery
32. Hip replacement
33. Sinus surgery
34. Benign tumors
35. Hysterectomy
36. Spinal fusion
37. Biopsy
38. Inguinal hernia
39. Splenectomy
40. Brain surgery
41. Kidney removed
42. Thyroid removed/irradiated
43. Breast augmentation (implants)
    - ❑ Saline
    - ❑ Silicone
44. Knee replacement
45. Tonsillectomy
46. Knee surgery
47. Tubes in ears
48. Laminectomy
49. Tubes tied (fallopian)
50. Bypass surgery
51. Laporscopy
52. Vasectomy
53. Cancer
54. Lung removed
55. OTHER SURGERY (list) _____ _____
56. Carpal tunnel surgery
57. Malignant tumors

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Patient name:_____

CONDITIONS YOU HAVE HAD OR BEEN DIAGNOSED WITH AT ANY TIME IN PAST

58. ADD/ADHD
61. Alcoholism
64. Allergies
- ❑ animal
- ❑ dust
- ❑ food
- ❑ grass
- ❑ mold
- ❑ pollen
- ❑ ragweed
- ❑ other

_____

_____

84. Anemia
- ❑ helped by taking iron
- ❑ not helped by taking iron

88. Angina
90. Anorexia
92. Appendicitis
95. Arthritis
98. Asthma
101. Athlete's foot
104. Bladder infections
107. Bleeding disorders
110. Breast lump/cysts
113. Bronchitis
116. Bulimia
119. Bursitis
122. Cancer
125. Cataracts
128. Cavities (dental) FEW SOME MANY
131. Chicken pox
134. Diabetes
135. Depression
136. Drug abuse history
59. Emphysema
62. Epilepsy
65. Eczema
67. Fibromyalgia
69. Fractures
71. Frequent colds/flus
73. Gastritis
75. Glaucoma
77. Gonorrhea
79. Gout
81. Heart disease
82. Hepatitis
83. Hernia
85. Herpes (mouth)
86. Herpes (genital)
87. High blood pressure
89. High cholesterol
91. HIV positive
93. Hypoglycemia
96. Kidney disease
99. Liver disease
102. Low blood pressure
105. Manic depression
108. Measles
111. Menopause
114. Migraine headaches
117. Miscarriage
120. Mononucleosis
123. Multiple sclerosis
126. Mumps
129. Osteoporosis
132. Pregnancies #____
- ❑ number of vaginal births #____
- ❑ number of caesarian births #____
- ❑ number of abortions #____

60. Pneumonia
63. Polio
66. Prostate problem
68. Psoriasis
70. Psychiatric care
72. Rheumatoid arthritis
74. Rheumatic fever
76. Ringworm
78. Scarlet fever
80. Sensitivities
- ❑ cigarette smoke
- ❑ exhaust
- ❑ food
- ❑ gas
- ❑ perfume/cologne
- ❑ other (list)

_____

_____

94. Shingles
97. Sinusitis, Acute or Chronic
100. Stroke
103. Suicide attempt
106. Tendinitis
109. Thyroid problems
112. Tonsillitis
115. Tuberculosis
118. Tumors/growths
121. Typhoid fever
124. Ulcers
127. Vaginal infections
130. Whooping cough
133. OTHER CONDITIONS

_____

_____

_____

JOINT, MUSCLE, BONE SYMPTOMS (in the past year)

137. Entire body aches, painful to touch
140. Chronic pain
142. Bones sore and painful
144. Swollen joints
146. Tingling pain sensation
149. Muscle spasms
151. Muscle twitching
153. Muscle cramps
155. Leg cramps at night
138. Leg cramps during activity
141. Calf muscles cramp while walking
143. Loss of muscle tone
145. Poor flexibility
147. Poor posture
150. Pinched nerve in low back
152. Muscle spasms in low back
154. Tightness in shoulder muscles
139. Low back pain
- ❑ aggravated by prolonged sitting
- ❑ aggravated by prolonged standing
- ❑ aggravated by heavy lifting

148. Low back
- ❑ pain
- ❑ stiffness or tightness
- ❑ weakness

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Patient name:_____

JOINT, MUSCLE, BONE SYMPTOMS (in the past year)

156. Pain (specify on pain diagram)
- ❑ buttocks
- ❑ hip
- ❑ along outside of leg
- ❑ knee
- ❑ ankle
- ❑ foot/toes
- ❑ big toe only
- ❑ middle back
- ❑ shoulder
- ❑ left arm
- ❑ upper arm
- ❑ right side under rib cage
- ❑ left side under rib cage
- ❑ shoots from front to back
- ❑ chest
- ❑ chest pain while walking
- ❑ chest or back with deep breath in
- ❑ between shoulder blades
- ❑ elbow
- ❑ forearm
- ❑ hand
- ❑ fingers

157. Neck
- ❑ weakness
- ❑ pain
- ❑ stiffness
- ❑ muscle spasms
- ❑ grinding/popping sounds
- ❑ crink in neck on occasion
- ❑ pinched nerve sensation

164. Weakness
- ❑ arm
- ❑ hand
- ❑ fingers
- ❑ leg
- ❑ middle back

171. Headaches
- ❑ back of the head
- ❑ temples
- ❑ one-sided left right
- ❑ after eating
- ❑ migraine
- ❑ relieved by eating sweets/alcohol
- ❑ during menstrual period
- ❑ sinus

158. Pins & needles or numbness
- ❑ arm/hand/fingers
- ❑ hip/leg/foot

159. Burning in: hands feet

160. Loss of feeling in: hands feet

161. Trembling hands

162. Loss of grip strength

163. Middle back stiffness

165. Can't raise arm above shoulder level

166. Can't raise arm over head

167. Pinched nerve sensation in shoulder

168. Cold hands

169. Cold feet

170. Double jointed

172. Can dislocate shoulder or hip

173. Get injured easily

174. Injuries heal slowly

175. Bursitis/tendonitis

183. Swelling of feet and ankles

184. Limbs feel too heavy to hold up

185. Heaviness in legs

GASTROINTESTINAL SYMPTOMS (in the past year)

186. Frequent/routine burping

187. After eating …
- ❑ Fatigue/sleepiness within 1-3 hrs
- ❑ Indigestion 1-3 hrs
- ❑ Stomach pains better
- ❑ Fullness for extended time
- ❑ Heartburn
- ❑ Calmer
- ❑ Craving not relieved
- ❑ Bloating, belching, or gas w/I 1 hr

188. Abdominal cramps

189. Find it hard to burp

190. Chronic abdominal pain

191. Abdominal bloating

192. Lower bowel gas

193. Sudden, acute indigestion

194. History of constipation

195. Relief of symptoms with carbonated drinks

196. Alternating constipation and diarrhea

198. Diarrhea for more than 3-4 days

199. Feel like you would collapse if went without food.

197. Stomach upsets easily

200. Nausea with taking pills

201. Butterfly sensations in stomach

202. Stomach pains
- ❑ when emotionally upset
- ❑ made better by eating
- ❑ increased by eating
- ❑ increased by stress with acidic foods

203. Poor appetite

204. Eat all the time

205. Eat good amount of meat

206. Crave sweets

207. Certain foods make you sick

208. Crave breads/bakery

209. Intolerance to greasy food

210. Thirsty all the time

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SKIN, HAIR, NAIL SYMPTOMS (in the past year)

211.	Toe and fingernail fungus	212.	Skin rashes	213.	Nails peel, crack, break easily
214.	Thick skin and finger nails	215.	Spider veins on nose and/or face	216.	Skin tags
217.	Grey colored skin	218.	Chronic leg sores	219.	Acne
220.	Puffy, wrinkly skin	221.	Get boils or sties	222.	Dry, flaky skin and/or dry brittle hair
223.	Bumpy skin on back of arms	224.	Poor wound healing	225.	Hair falls out
226.	Thinning/loss of outside portion of eyebrows	227.	Bruises easily	228.	Hair grows slowly

EAR, EYE, NOSE, MOUTH SYMPTOMS (in the past year)

229.	Yellow in whites of eyes	230.	Ear infection	231.	Breathe through mouth
232.	Swollen (bulging) eyes	233.	Ear discharge or ears stuffed up	234.	Inflamed or bleeding gums
235.	Itchy eyes	236.	Ringing and/or buzzing in ears	237.	Cold sores, fever blisters
238.	Red or inflamed eyes	239.	Nasal congestion	240.	Sour taste in mouth
241.	Discharge from eyes	242.	Running nose	243.	Swollen tongue
244.	Watery eyes	245.	Itching of nose	246.	Bad breath
247.	Puffiness or dark circles under eyes	248.	Loss of smell	249.	Loss of taste
250.	Eyes sensitive to bright light	251.	Nose bleeds	252.	Itching of roof of mouth or throat
253.	Failing eyesight	254.	Mucous in throat	255.	Throat infections
256.	Loss of vision when standing suddenly	257.	Post nasal drip	258.	Difficulty swallowing

KIDNEY, URINARY TRACT SYMPTOMS (in the past year)

259.	Frequent urination	260.	Dripping after urination	261.	Strong smelling urine
262.	Rarely need to urinate	263.	Painful/burning when passing urine	264.	Cloudy urine
265.	Urination when you cough or sneeze	266.	Difficulty urinating	267.	A sense of bladder fullness
268.	Wake up to urinate at night 1 2 3 4 5	269.	Back leg pain associated with dripping after urination	270.	Increased straining with less urine passed
271.	Can't hold urine	272.	Rose colored (bloody) urine	273.	General water retention

ENERGY, MOOD, MEMORY SYMPTOMS (in the past year)

274.	Chronic fatigue	275.	Slurred speech	276.	Depression
277.	Trouble waking up in the morning	278.	Lack of mental alertness	279.	Hyperactivity
280.	Feel tired in the afternoon	281.	Poor concentration	282.	Impatience
283.	Feel weak and shaky	284.	Poor memory	285.	Moodiness
286.	Feel jittery	287.	Sugar causes irritability and mood swings	288.	Nervousness
289.	Convulsions	290.	Apathy	291.	PMS

LUNGS, IMMUNITY SYMPTOMS (in the past year)

292.	Sensitive to exhaust fumes/smoke/smog, chemicals	293.	Severe cough	294.	Difficulty breathing
295.	Catch colds easily when weather changes	296.	Cough up blood	297.	Difficulty breathing at night
298.	Swollen lymph glands	299.	Coughing up phlegm	300.	Rattling mucous when you breath
301.	Slow to recover from colds or flu's	302.	Wheezing	303.	Infections tend to settle in lungs
304.	Catch colds or flu easily	305.	Sneezing	306.	Live or work around people who smoke
307.	Lung congestion	308.	Shortness of breath	309.	Regularly exposed to fumes

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CARDIOVASCULAR SYMPTOMS (in the past year)

310.	Heart pounds easily	311.	Rapid beating heart	312.	Feel energized from exercise
313.	Heart misses beats or has extra beats	314.	Regular Aerobic exercise?	315.	Exhaustion on slightest effort
316.	Heart flutters	317.	Ever exercised regularly?	318.	Blushing for no apparent cause
319.	Heart trouble	320.	Can't tolerate much exercise		

SLEEP SYMPTOMS (in the past year)

321.	Intense dreams	322.	Restless leg at night	323.	Can't fall asleep
324.	Nightmares	325.	Restless uneasy sleeper	326.	Need for 10-12 hours sleep/night
327.	Never remember dreams	328.	Awake frequently throughout the night	329.	Night sweats
330.	Sleep walk	331.	Wake up at night, can't fall back to sleep	332.	Bedwetting

MISCELLANEOUS SYMPTOMS (in the past year)

333.	Body odor	334.	Gain weight easily	335.	Light headedness/fainting
336.	Cold sensitive	337.	Difficulty gaining weight	338.	Loss of balance
339.	Axillary (armpit) temperature below 97.6'F	340.	Overweight	341.	Uncoordinated
342.	Infertility	343.	Dizziness	344.	Accident prone
		345.	Dizziness or "headrush" on standing	346.	Head feels heavy

Family History

- ❑ Diabetes
- ❑ Gestational Diabetes
- ❑ Hypoglycemia
- ❑ Food allergies
- ❑ Cancer
- ❑ Stroke
- ❑ Heart Disease
- ❑ Alcoholism
- ❑ Substance abuse
- ❑ Depression
- ❑ Migraine headaches
- ❑ Varicose veins

Vaccinations

- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Chicken Pox
- ❑ Pneumonia/Flu-# of times ___
- ❑ Hepatitis B
- ❑ Polio
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Tetanus

Frame size

- ❑ Small boned?
- ❑ Medium frame?
- ❑ Large frame?

Exercise

- ❑ No exercise
- ❑ Very little exercise
- ❑ 1-2 aerobic sessions per week
- ❑ 3-4 aerobic sessions per week
- ❑ 5 or more aerobic sessions per week
- ❑ Cannot tolerate much exercise

Ideal Weight

Lbs

Circle Blood Type

- ❑ A positive
- ❑ A negative
- ❑ B positive
- ❑ B negative
- ❑ O positive
- ❑ AB positive
- ❑ O negative
- ❑ AB negative

Ethnicity

- ❑ Caucasian
- ❑ Asian
- ❑ African
- ❑ American Indian
- ❑ Hispanic
- ❑ Jewish
- ❑ Middle Eastern
- ❑ Pacific Islander
- ❑ Other (describe) _____

By signing below, I acknowledge the above to be true to the best of my knowledge.

Signature _____ Date _____ Doctor's Initials/date _____

NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member 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.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.

6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time

frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

_____ (Name or office)

_____ (Address)

_____

_____ (Phone)

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.