Patient Basic Information

Personal Information:

First Name:

Last Name:

Middle Initial:

Address:

City, State, Zip:

Home Phone: Work Phone:

Social Security No:

Date of Birth:

Date of Injury/Onset:

Dominant Hand: ○ Right ○ Left ○ Both

Insurance Information:

Policy Holder (if different than patient):

Policy No: Claim No:

Description of Accident/Injury/Onset

If this is an automobile accident, you can use the MVA Section.

During and after accident details

Enter details of your condition during and after the injury/onset.

Automobile Accident Description

Your Vehicle Type:

○Car ○S.U.V. ○Van ○Bus
○Large Truck ○Pickup Truck

Other Type:

Your Position in Vehicle

○Driver ○Front Passenger
○ L.Rear Passenger ○ R.Rear Passenger

Other Position:

Time/Speed/Damage

Time of Accident: Your Speed
Their Speed

Damage to your vehicle:

○Mild ○Moderate ○Totaled

What was your vehicle doing at time of accident?

○ Stopped at intersection ○ Stopped in traffic ○ Stopped at a light
○ Making a right turn ○ Making a left turn ○ Parking
○ Proceeding along ○ Slowing down ○ Accelerating

Other:

Details of Accident:

Visibility at the time:
○ Good ○ Fair ○ Poor

Road Conditions at Time of Accident:
○ Icy ○ Wet ○ Sandy
○ Dark ○ Clean & Dry

Point of Impact:
○ Head-On ○ Rear-End
○ Left front ○ Right front
○ Left rear ○ Right rear

Other:

Who hit who/what:
○ You hit other vehicle
○ Other vehicle hit you
You hit....(Type in object below)

Other:

Additional Accident Information:

In the case of a motor vehicle accident, write any additional info here.

During the Accident:

Body Position, etc.

Did you see the accident coming?..... Yes ☐☐ No
Were you braced for the impact?.....Yes ☐☐ No
Did you have a seat belt on?..... Yes ☐☐ No
Did you have a shoulder harness on? Yes ☐☐ No
Did the driver's front air bag deploy?.. Yes ☐☐ No
Did passenger front air bags deploy? Yes ☐☐ No
Did the side air bags deploy?..... Yes ☐☐ No
Does your vehicle have headrests?... Yes ☐☐ No

Headrest Position?

○ Even with top of head
○ Even with bottom of head
○ Even with middle of the neck

What was the direction of the head at the time of impact?

○ Facing straight forward ○ Turned to the right ○ Turned to the left

Did your body strike the inside of your vehicle?.....Yes ☐☐ No

If Yes, describe:

Did you lose consciousness during the injury?.....Yes ☐☐ No

If Yes, for how long?

Your vehicle's Estimated Damage:

Damage to their vehicle:

○ Mild ○ Moderate ○ Totaled

Did police show up at the scene? Yes ☐☐ No

Was an accident report filled out? Yes ☐☐ No

Emergency Room?

Where did you go after the accident?

○ Home ○ Work
○ Hospital ER ○ Private doctor

How did you get there?

○ Drove Self ○ Ambulance
○ Somebody Else ○ Police

X-rays done? Yes ☐☐ No

Was lab work done? Yes ☐☐ No

Body parts X-rayed?

What lab work?

The x-rays revealed..

Treatments: ☐ Cervical Collar ☐ Ice Other

Medications:

Follow-up Instructions:

After the Accident:

Check off the symptoms right after and a few days following the accident.

☐ Headache ☐ Loss of smell ☐ Tension ☐ Loss of taste ☐ Diarrhea
☐ Neck pain ☐ Dizziness ☐ Irritability ☐ Toe numbness ☐ Depression
☐ Neck stiffness ☐ Nausea ☐ Mid back pain ☐ Constipation ☐ Anxious
☐ Fainting ☐ Confusion ☐ Low back pain ☐ Cold hands ☐ Chest pain
☐ Ringing in ears ☐ Fatigue ☐ Nervousness ☐ Cold Feet
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems

Others:

Doctor's Additional Data on This Patient

NOTE: This will be entered into the chart, but will not appear in Reports

Patient's Signature: **Date:**

Historical Information

Prior Treatment Information

Prior Similar Symptoms:
- ❍ I have NOT had prior similar symptoms to current complaints.
- ❍ My current complaints DID exist before, but had been dormant.
- ❍ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Symptoms?
- ❍ My history HAS contributed to my current symptoms.
- ❍ My history HAS NOT contributed to my current symptoms.
- ❍ I'm NOT SURE if my history has contributed to my symptoms.

My Most Recent Prior Similar Symptoms (if applicable)

My most recent prior similar symptons occurred…

☐ ❍ Months ❍ Years…ago **OR** on (Date) ☐

Medical History Section:
Enter additional Medical Historical data here.

Surgical Historical Section:
Enter any Surgical Historical data here.

Treatment History 1:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ☐☐ No Currently Treating? Yes ☐☐ No

X-rays done? Yes ☐☐ No

Medications History Section:
Enter any Medications Historical data here.

Occupational History Section:
Enter Occupational History, e.g. lost work, etc. Here.

Treatment History 2:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ☐☐ No Currently Treating? Yes ☐☐ No

X-rays done? Yes ☐☐ No

Familial History Section:
Enter relevant Familial History here.

Social History Section:
Enter any relevant Social History here.

Treatment History 3:
Fill in any other doctor(s) seen prior to your first visit to this office.

1. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ☐☐ No Currently Treating? Yes ☐☐ No

X-rays done? Yes ☐☐ No

Additional Historical Information Section:
Summarize other treatments that were received here.

Prior Treatment Section:
Summarize past treatments received here.

Treatment History 4:
Fill in any other doctor(s) seen prior to your first visit to this office.

4. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ☐☐ No Currently Treating? Yes ☐☐ No

X-rays done? Yes ☐☐ No

Patient's Signature:_____ **Date:**_____

Current Complaints

1. Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw..... LO RO BO
- ❑ Eye..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest..... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs..... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Types of Pain:

❑Dull ❑Numbing
❑Throbbing ❑Shooting
❑Spasm ❑Cutting
❑Sharp ❑Tingling
❑Burning ❑Pounding
❑Stinging ❑Cramping
❑Aching ❑Constricting

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head.....LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm.....LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates

R=Relieves	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑

Other Actions:

	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

Additional Data on above Symptom

2. Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw..... LO RO BO
- ❑ Eye..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest..... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs..... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Types of Pain:

❑Dull ❑Numbing
❑Throbbing ❑Shooting
❑Spasm ❑Cutting
❑Sharp ❑Tingling
❑Burning ❑Pounding
❑Stinging ❑Cramping
❑Aching ❑Constricting

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm.....LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates

R=Relieves	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑

Other Actions:

	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

Additional Data on above Symptom

3. Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw..... LO RO BO
- ❑ Eye..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest..... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs..... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Types of Pain:

❑Dull ❑Numbing
❑Throbbing ❑Shooting
❑Spasm ❑Cutting
❑Sharp ❑Tingling
❑Burning ❑Pounding
❑Stinging ❑Cramping
❑Aching ❑Constricting

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head..... LO RO BO
- ❑ Neck..... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm.....LO RO BO
- ❑ Hand..... LO RO BO
- ❑ Hip..... LO RO BO
- ❑ Leg..... LO RO BO
- ❑ Foot..... LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates

R=Relieves	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑

Other Actions:

	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

Additional Data on above Symptom

Patient's Signature:_____ **Date:**_____

Activities of Daily Living

Activities of Daily Living Scale #1
Use the following 1 to 5 Scale to describe the difficulties below, down through Travelling.

1 - "I can do it without any difficulty."
2 - "I can do it without much difficulty, despite some pain."
3 - "I manage to do it by myself, despite marked pain."
4 - "I manage to do it, despite the pain, but only if I have help."
5 - "I cannot do it at all, because of the pain."

Difficulties with Self Care and Personal Hygiene Activities:
Bathing. ☐ Drying hair.. ☐ Brushing teeth.. ☐ Putting on shoes.. ☐ Preparing meals.. ☐ Taking out trash. ☐ Showering.. ☐ Combing hair.. ☐ Making bed... ☐
Tying shoes.. ☐ Eating... ☐ Doing laundry... ☐ Washing hair... ☐ Washing face... ☐ Putting on shirt.. ☐ Putting on pants. ☐ Cleaning dishes. ☐ Going to toilet.. ☐

Difficulties with Physical Activities:
Standing..... ☐ Walking.. ☐ Kneeling... ☐ Bending back. ☐ Twisting left. ☐ Leaning back... ☐ Sitting... ☐ Stooping.. ☐ Reaching.. ☐
Bending left.. ☐ Twisting right... ☐ Leaning left.. ☐ Reclining... ☐ Squatting... ☐ Bending forward.. ☐ Bending right.. ☐ Leaning forward.. ☐ Leaning right.. ☐
Standing for long periods... ☐ Sitting for long periods.. ☐ Walking for long periods... ☐ Kneeling for long periods... ☐

Difficulties with Functional Activities:
Carrying small objects... ☐ Lifting weights off floor.. ☐ Pushing things while seated.. ☐ Exercising upper body.. ☐ Carrying large objects.. ☐ Lifting weights off table.. ☐
Pushing things while standing.. ☐ Exercising lower body... ☐ Carrying brief case.. ☐ Climbing stairs... ☐ Pulling things while seated... ☐ Exercising arms.. ☐
Carrying large purse.. ☐ Climbing inclines... ☐ Pulling things while standing.. ☐ Exercising legs... ☐

Difficulties with Social and Recreational Activities:
Bowling... ☐ Jogging. ☐ Swimming.. ☐ Ice skating.. ☐ Competitive sports.. ☐ Dating.. ☐ Golfing.. ☐ Dancing.. ☐ Skiing.. ☐
Roller skating.. ☐ Hobbies.. ☐ Dining out... ☐

Difficulties with Travelling:
Driving a motor vehicle.. ☐ As a passenger in a motor vehicle... ☐ As a passenger on a train.. ☐ Driving for long periods of time... ☐ As airplane passenger. ☐

Activities of Daily Living Scale #2
Use the following 1 to 5 Scale to describe the difficulties below

1 - "This area is not affected by my condition."
2 - "This area is slightly affected by my condition."
3 - "My condition moderately restricts my ability in this area."
4 - "My condition seriously limits my ability in this area."
5 - "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication:
Concentrating... ☐ Hearing.. ☐ Listening... ☐ Speaking.. ☐ Reading... ☐ Writing... ☐ Using a keyboard... ☐

Difficulties with the Senses:
Seeing .. ☐ Hearing... ☐ Touch.. ☐ Taste.. ☐ Sense of Smell. ☐

Difficulties with Hand Functions:
Grasping... ☐ Holding... ☐ Pinching... ☐ Percussive movements.. ☐ Sensory discrimination.. ☐

Difficulties with Sleep and Sexual Activity:
Being able to have a normal, restful nights sleep..... ☐
Being able to participate in desired sexual activity... ☐

Additional Activities of Daily Living Information:

Patient's Signature:_____ **Date:**_____

Health Conditions

Please check any conditions that currently exist or have existed in the past:

	For women:	
	Are you pregnant?	___Yes ___No
	Are you nursing?	___Yes ___No
	Do you experience painful periods?	___Yes ___No
	Do you have irregular cycles?	___Yes ___No
	Are you taking birth control?	___Yes ___No
	Do you have breast implants?	___Yes ___No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all expenses incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient's Signature Date Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account:

____ Patient	____ Spouse	____ Parent
____ Worker's Comp	____ Auto Insurance	____ Medicare
____ Medicaid	____ Personal Health Insurance	

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays are for examination of X-rays only. The X-ray negatives will remain the property of this office. All X-rays will be kept on file where they may be seen at any time while I am a patient of this office.

CONSENT TO TREATMENT OF MINOR

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize_____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. These authorizations shall remain effective until _____, 20_____, unless sooner revoked in writing delivered to the agent(s) noted above.

_____

Parent/legal guardian / Person having legal custody (circle relationship) Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

To locate, analyze, and correct spinal interference to the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

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WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS

WE OFFER NO OTHER TREATMENT OF CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

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I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

SIGNATURE:_____ DATE:_____

Canyon Chiropractic Dedicated to Quality Care

NEW PATIENT INSURANCE REGISTRATION FORM

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We work with hundreds of different insurance companies that administer insurance benefits from different employers. Each employer pays an insurance premium for specific chiropractic coverage. Each plan is slightly different depending on how the employer has negotiated benefits with the insurance company. Companies often change insurance companies in an effort to secure better benefits for smaller premiums. We encourage you to become familiar with your policy maximums, percentages, exclusions, deductible and required co-payments.

We do not base your adjustment program on your insurance coverage and neither should you. There are limits to what they will pay. Our goal is to correct your problem in the shortest amount of time and in the most cost-effective manner.

Our courtesy service to you includes:

1. Researching your chiropractic insurance plan to advise you of benefits available to you.
2. Filing your insurance within 14 days of your visit and requesting payment of benefits to our office when possible.
3. Follow up on chiropractic claims to assist with claim processing and payment.

Our expectations of you as the owner of the insurance policy:

1. Payment of fees not covered by your insurance plan.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Taking responsibility for payment if the insurance company does not pay our office.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **please sign the "assignment of benefits"** below to allow us to file your insurance claims.

I hereby authorize Dr. Robert C. Dees to release to my insurance company, information acquired in the course of my chiropractic care. I hereby authorize benefits to be paid to Dr. Robert C. Dees. I understand I am responsible for any unpaid balance.

Signature:_____ **Date:**_____

Provider Privacy Policy

THIS NOTICE DESCRIBES HOW 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

Treatment: Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the daily operations and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to assist in government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Marketing: We may use your oral or written testimony, with your permission, for marketing the benefits of our office.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Supplier's duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Canyon Chiropractic**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about your privacy practices, you can do so by sending a letter outlining your concerns to:

Canyon Chiropractic
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person: The name and address of the person you may contact for further information concerning our privacy practices is:

Robert C. Dees, DC
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583
(925) 867-1414

The undersigned hereby acknowledges that he/she has read and understood the policies of the supplier.

Signature _____ Date _____ Print Name _____

Effective Date: This notice is effective after January 5, 2011