

Flagler Chiropractic Clinic 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.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is in effect as of April 14, 2003 and will remain in effect until we replace it.

Changes to Notice:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

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.

Permitted uses and disclosures of Health Information:

****Treatment, payment, healthcare operations:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations.

Examples of these activities are as follows:

Treatment: We may use or disclose your health information to other healthcare providers providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

****Authorizations:** You may specifically authorize us to use your health information for any purpose or disclose your health information to anyone, by submitting such an authorization in writing.. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot disclose your health information for any reason except those permitted by this Notice.

****Disclosures to family and personal representatives:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or for payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on the determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

****Marketing:** We will not disclose your health information for marketing communications without your written authorization.

****Use or disclosures required by law:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g. disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

****Patient and third party protection:** Only as permitted by law, 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.

****Law enforcement/national security:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose certain health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of

those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other security activities.

****Appointment reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

Patient Rights:

****Access to records:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee 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 if you are interested in receiving a summary of your information instead of copies.

****Restrictions and alternative communications:** Upon written request, you have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, 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.

****Amendments to records:** You have the right to request that we amend your health information. Such requests must be made in writing, and 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 format.

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 or any decisions we make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You may also submit a written request to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. 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 the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Dr. Sidi M. Lemnoui
Dr. Adam S. Lemnoui

1240 S. A1A
Flagler Beach, Fl 32136

Phone: 386-439-9001

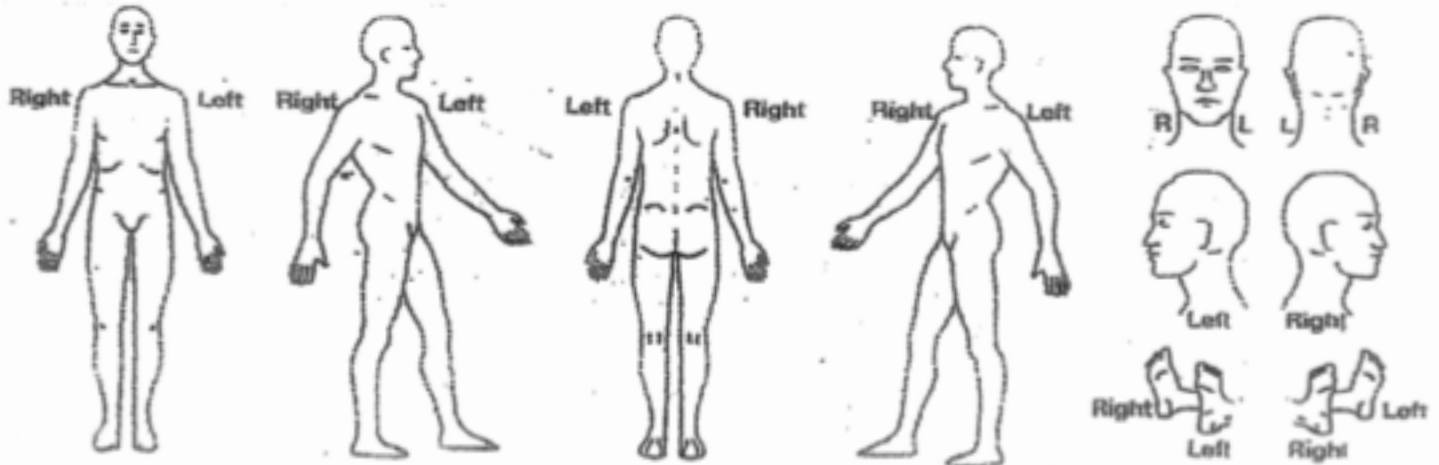
FLAGLER
CHIROPRACTIC, P. A.
www.flaglerchiropractic.com

Tel: 386-439-9001
Fax: 386-439-9002

Dr. Sidi M. Lemnoui
Dr. Adam S. Lemnoui

Patient's Name _____ Date _____

- 1) PAIN DRAWING (Please indicate the area in which you are presently experiencing pain and indicate any area that the pain refers.)



- 2) Please mark an "X" on the line scale below indicating your level of pain.

Severe Pain _____ No Pain

- 3) Describe any new symptoms or changes in your condition:

Patient's Signature _____



WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." — Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____

First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birthdate _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (____) _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (____) _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone (____) _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Health History

Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? No Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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.

The above-named doctor may use my health care 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.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Flagler Chiropractic Clinic

Consent for Purposes of Treatment, Payment and HealthCare Operations

I, _____ consent to Flagler Chiropractic Clinic's use and disclosure of my Protected Health information for the purposes of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; or the the past, present or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment of healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy prior to signing this document. The Notice of Privacy Practices describes my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the chiropractor of the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority