



NOTICE OF PRIVACY PRACTICES

Patient name (please print): _____

All health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Call you on your mobile, at home, or place of business to remind you of scheduled or missed appointments
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker’s compensation
- Discussing your claim(s)

You have the right to:

- Request a copy of your health record
- Request with whom we share your health information
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your health information

Consultation and Exam

To begin today’s visit, we will collect confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests. If we believe we may help you, we will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of findings from the recorded history, consultation, and examination. If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan will be developed to address your short-term and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy.
- I understand any questions can be directed to clinic management.
- I understand the purpose of today’s visit.
- The doctor(s), employees, or designated agents of this clinic may use my protected health information in the manner previously described.

Signature of patient, parent, or legal representative/guardian

Date

Printed name of patient, parent, or legal representative/guardian

Relationship to patient