SIMPLE TRUTH CHIROPRACTIC

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:

Simple Truth Chiropractic, PLLC

2757 Leonard St NE #200

Grand Rapids, MI 49525

616-458-8063

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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.

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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).

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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.

_____

Printed Name - Patient or Representative

_____

Signature Date

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Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Simple Truth Chiropractic, PLLC for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Simple Truth Chiropractic, PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Simple Truth Chiropractic, PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Printed Name - Patient or Representative

_____

Signature Date

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INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Printed Name - Patient or Representative

_____

Signature Date

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NEW PRACTICE MEMBER INTAKE FORM

Demographics:

First Name	Last Name	Date of Birth
Phone	Gender	Email
Street Address	Zip	City/State

Chief Complaints:

Health Concern:	Frequency:	Quality of/ Describe Pain:	Severity (1-10): 1-mild 10-worst	What aggravates it?	What relieves it?

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Lifestyle:

Tobacco Use Frequency		Effective Date	
Alcohol Use Frequency		Effective Date	
Exercise Frequency		Effective Date	

Medical History:

Hospitalizations:	
Surgeries:	
Prior Accidents/Injuries:	
Ongoing Illness:	
Allergies:	
Current Medications:	
Family History:	
Social History:	
Sexual History:	
Previous Tests:	
Medical Procedures:	
Dietary Habits:	
Nutritional Supplements:	
Prior Chiropractic Care:	

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Review of Systems:

	General
	WNL
	Lethargy/Weakness
	Recurring Fever
	Recent weight change
	Dizziness
	Fever
	Chills
	Others:

	HEENT
	WNL
	Headaches or Migraines
	Eye or vision problems
	Eyeglasses or contacts
	Nose bleeds
	Eye surgery
	Cataracts
	Glaucoma
	Sore throat
	Hoarsness
	Swollen glands
	Nose congestion
	Ear or hearing problems
	Dental problems
	Gum problems
	TMJ problems
	Postnasal drip
	Others:

	Skin/Hair
	WNL
	Skin trouble or rashes
	Flushing
	Excessive acne
	Eczema
	Psoriasis
	Skin cancer
	Skin pigmentation issues
	Change in hair or nails
	Blood in stool
	Easy bruising
	Gum bleeding
	Others:

	Cardiovascular
	WNL
	Chest pain or tightness
	Heart attack
	Shortness of breath
	Palpitations
	Swelling of feet or hands
	High blood pressure
	High cholesterol
	Heart murmur
	Blood clots
	Pacemaker
	Mitral valve prolapse
	Congential heart defects
	Rheumatic fever
	Leg pain upon walking
	Varicose veins
	Dizziness
	Excessive brusing
	Coronary artery disease
	Others:

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	Respiratory
	WNL
	Persistent cough
	Spitting up blood
	Asthma / wheezing
	Shortness of breath
	Exercise intolerance
	Sleep apnea
	Emphysema
	Snoring issues
	Tuberculosis
	Pneumonia
	Breathing
	Hay fever
	Others:

	Gastrointestinal
	WNL
	Loss of appetite
	Nausea / vomiting
	Diarrhea
	Constipation
	Abdominal Pain
	Stomach ulcer
	Bloating / cramping
	Heartburn
	Hemorrhoids
	Hepatitis
	Cirrhosis
	Difficulty swallowing
	Jaundice
	Liver disease
	Gallbladder problems
	Pancreatitis
	Change in bower habits
	Black / bloody stool
	Colon cancer or polyps
	Food sensitivities
	IBS
	Crohn's disease
	Gastric reflux
	Collitis
	Others:

	Neurological
	WNL
	Frequent headaches
	Migraines
	Dizziness
	Fainting
	Memory loss
	Poor balance
	Numbness/tingling
	Pins/needles
	Epilepsy/seizures
	Stroke
	Tremors
	Head injury
	Anxiety/panic
	Depression
	Sleeping issues
	Weak muscles
	Loss of smell or taste
	Temporary loss of vision
	Difficulty concentrating
	Others:

	Musculoskeletal
	WNL
	Arthritis
	Joint pain/swelling
	Neck pain
	Back pain
	Trauma
	Osteoporosis
	Scoliosis
	Cramping
	Fractures
	Implants,plates,pin
	Hip disorder
	Knee Injuries
	Foot/ankle pain
	Shoulder problems
	Elbow/wrist pain
	Poor posture
	Gout
	Others:

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	Blood/Lymph
	WNL
	Anemia
	Bleeding
	Brusing
	Blood clots
	Past transfusions
	Leukemia
	Lymphona
	HIV/AIDS
	Sickle cell
	Others:

	Allergies
	WNL
	Seasonal
	Medication
	Food
	Others:

	Psychiatric
	WNL
	Alzheimer's disease
	Insomnia
	Difficulty concentrating
	Memory loss/confusion
	Depression
	Anxiety
	Agitation/irritability
	Suicidal thoughts
	Chemical dependency
	Others:

	Endocrine
	WNL
	Diabetes
	Thyroid problems
	Sweating
	Heat intolerant
	Cold intolerant
	Weight loss
	Weight gain
	Frequent urination
	Excessive thirst
	Change in appetite
	Hair changes
	Hyperthyroidism
	Hormonal/glandular
	Hyperparathyroidism
	Testosterone deficiency
	Cushing's syndrome
	Steroid treatments
	Others:

	Urinary
	WNL
	Painful urination
	Incontenence
	Hesitancy
	Urgency
	Blood in urine
	Kidney stones
	Urinary infections
	Genital/bladder/urinary
	Others:

	Male
	WNL
	Dribbling
	Loss of libido
	Erectile dysfunction
	STD
	Testicular pain/lumps
	Prostate disease
	Penile discharge
	Others:

	Female
	WNL
	Painful sex
	Vaginal Discharge
	Breast pain/lumps
	Hot flashes
	Menstrual Irregularty
	Loss of libido
	Menopause
	STD
	Others:

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Authorization:

I certify that I'm the patient or the legal guardian of the patient listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

_____

Printed Name - Patient or Representative

_____

Signature Date