PATIENT HISTORY

Date _____ Case number _____

Name _____ Phone (h) _____ (w) _____

Address _____ DOB _____ Age _____ Sex: M F

Occupation _____ Employer _____ Driver's Lic.# _____

Social Sec # _____ Insurance Company _____ Referred by _____

Marital Status: S M D W Email address: _____

Spouse's Name _____ DOB _____ Spouse's Social Sec # _____

Spouse's Employer _____ Spouse's Occupation _____

Spouse's Driver's Lic.# _____ Spouse's Insurance Co _____

Past chiropractic care ___ Y ___ N When? _____ Doctor's Name _____

Results _____

Chief complaint #1 _____

Chief complaint #2 _____ Chief complaint #3 _____

Are your present injuries due to an injury? ☐ No ☐ Yes: ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other

Have you made a report of your accident? ☐ No ☐ Yes: ☐ To employer ☐ Auto Carrier ☐ Other

Has the accident been reported? ☐ No ☐ Yes: ☐ Worker's comp ☐ Auto Accident ☐ Other

Are you now or have you ever been disabled (service or work)? ☐ No ☐ Yes: When: _____

Have you retained an attorney? ☐ No ☐ Yes: Name & address: _____

PLEASE GIVE MOST CURRENT DATE

Spinal exam _____

Disc exam _____

X-ray _____

Lab exam _____

Last physical _____

DOCTORS USE ONLY:

_____

_____

_____

_____

_____

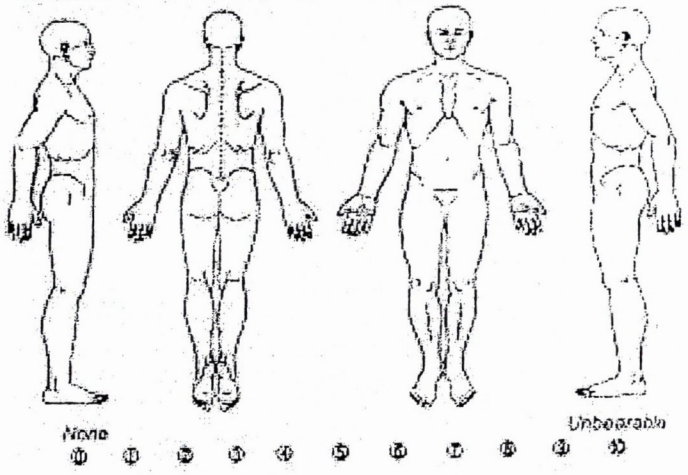
_____

_____

_____

_____

Indicate where you have pain or other symptoms



HABITS

☐ Smoking packs/day_____

☐ Drinking alcohol_____

☐ Coffee cups/day_____

EXERCISE

☐ None

☐ Moderate

☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother No. of___	☐	☐	☐	☐	☐
Sister No. of___	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? Please check those that apply:

__ Appendicitis	__ Anemia	__ Heart Disease	__ Arthritis
__ Pneumonia	__ Measles	__ Goiter	__ Epilepsy
__ Rheumatic fever	__ Mumps	__ Influenza	__ Mental Disorder
__ Polio	__ Chicken Pox	__ Pleurisy	__ Lumbago
__ Tuberculosis	__ Diabetes	__ Alcoholism	__ Eczema
__ Whooping cough	__ Cancer	__ Venereal Infection	__ AIDS

SIGNS & SYMPTOMS: Please check those that apply, using "C" for current and "P" for past

GENERAL
headache
fever
chills
night sweats
fainting
dizziness
convulsions
loss of sleep
fatigue
nervousness
numbness/pain in arms, legs, hands
allergy (what:_____)
neuralgia

MUSCLE & JOINTS
weakness
twitching
stiff neck
backache
swollen joints
tremors
foot trouble
painful tail bone
pain between shoulders
spinal curvature

FOR WOMEN ONLY
painful periods
excessive flow
irregular cycles
hot flashes
cramps or backaches
miscarriage
vaginal discharge
pregnant at this time

GASTROINTESTINAL
poor appetite
poor digestion
excessive hunger
belching or gas
nausea
vomiting blood
pain over stomach
constipation
diarrhea
colon trouble
hemorrhoids (piles)
liver trouble
jaundice
gall bladder trouble

CARDIOVASCULAR
rapid heart
slow heart
high blood pressure
low blood pressure
pain over heart
previous heart trouble
swelling ankles
poor circulation
varicose veins

SKIN or ALLERGIES
skin eruptions
itching
bruising easily
dryness
boils
sensitive skin
hives or allergy
eczema

EYE/EARS/NOSE/THROAT
poor vision
crossed eyes
pain in eyes
deafness
earache
ear noises
ear discharges
nasal obstruction
nose bleeds
sore throats
hoarseness
hay fever
asthma
frequent colds
enlarged thyroid
tonsillitis
sinus trouble

RESPIRATORY
chronic cough
spitting blood
spitting phlegm
chest pain
difficulty breathing

GENITOURINARY
frequent urination
painful urination
blood in urine
bed wetting
inability to control
prostate trouble

OPERATIONS & PROCEDURES: PLEASE LIST DATES

_____ vaccinations	_____ tubes in ears	_____ sinus
_____ tonsillectomy	_____ appendectomy	_____ hernia
_____ gall bladder	_____ female organs	_____ thyroid
_____ back operations	_____ rectal surgery	_____ stomach
_____ other	_____ other	_____ other

Have you had any accidents or falls (if yes, please list dates): ☐ car_____

☐ sports _____ ☐ school _____ ☐ recreational vehicle _____

☐ other _____

Have you had any broken bones or dislocations/fractures? _____

_____

Have you been on crutches? Why? _____

Have you ever had any spinal taps or spinal injections? _____

Have you been knocked unconscious? _____

Have you ever had a lapse of memory? _____

Have you ever had x-rays taken? When? _____ By whom? _____
Of what ailments were these pictures made? _____

Do you suffer from any condition other than that for which you are now consulting us?

_____

_____

Are you presently taking any medication (perscription or patent)? _____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier adn myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from my insurance carrier and that any amount authorized to be paid directly to the doctors office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic or physical therapy care. I give authority for these procedures to be performed. X-ray negatives are property of this office. They may be seen at any time while I am a patient at this office. The patient also agrees that he/she is responsible for all bills incurred here. The doctor will not be responsible for any pre-existing medically diagnosed condition nor any medical diagnosis.

PATIENT'S SIGNATURE_____ DATE_____

The NECK Bournemouth Questionnaire

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient name _____ Patient signature _____ Date _____

Bolton J, Humphreys BK. The Bournemouth Questionnaire: A short-form comprehensive outcome measure. II. Psychometric properties in neck pain patients. J Manipulative Physiol Ther 2002;25:141-148.

The BACK Bournemouth Questionnaire

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

   No pain — Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

   Not at all anxious — Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed — Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

   Have made it no worse — Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

   Completely control it — No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

Patient name _____ Patient signature _____ Date _____

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22:503-10

McMahon Chiropractic and Physical Therapy
Standard Financial Policy

We strive to exceed expectations and eliminate financial surprises for all of our patients. We want to partner with you in keeping your account accurate and up-to-date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records upon request.

All co-pays are due at time of service.

I understand that I am responsible for all charges not covered by insurance including but not limited to:

1. **All claims denied**
2. **Unpaid due to deductibles**
3. **Coinsurance partially paid due to arbitrary determination of usual & customary**
4. **All charges denied from a completed review for medical necessity**
5. **Non covered charges such as maintenance, wellness or preventative care**
6. **Chronic care when deemed not medically necessary**
7. **Non covered supplies**

I understand that if my health insurance does not include coverage for chiropractic and/or physical therapy benefits, I will be required to pay at the time of services. I further understand that I have the right to establish a payment plan when costs exceed my ability to pay. Payment Plan Contracts are available through the billing department.

Attention Medicare Patients: McMahon Chiropractic & Physical Therapy accepts Medicare assignment for chiropractic adjustments. I understand that Medicare does not cover x-rays, exams, therapies or supplies. I will sign an Advanced Beneficiary Notice and McMahon Chiropractic and Physical Therapy will submit my claims to Medicare first, then to secondary or supplemental insurance carriers on my behalf.

Patient Signature _____ Date _____

Parent or Guardian _____ Date _____

Relationship to Patient _____

Form date: 07/2012

McMahon

Chiropractic & Physical Therapy

AUTHORIZATION FOR RELEASE OF HEALTH CARE RECORDS

TO:

I authorize and request you to release to:

McMahon Chiropractic and Physical Therapy Clinic
3004 Golf Road, Suite 100
Eau Claire, WI 54701

Phone: (715) 834-4516
Fax: (715) 834-0552

The following health care records of

_____
(Patient) (Date of Birth)

Which are in your possession:

_____	All health care records
_____	Medication list/drug allergies
_____	In-patient records
_____	Out-patient records
_____	Emergency Room Records
_____	X-rays
_____	Other_____

I request that you make the above records available to McMahon Chiropractic and Physical Therapy Clinic by:

_____ Sending a copy

_____ Sending the original records for temporary use

These records are to be released to McMahon Chiropractic and Physical Therapy Clinic to enable them to render assistance to the patient concerning his/her health.

_____ _____
(Date of Signature) (Signature of Patient)

_____
(If patient is a minor, signature guardian, or legal custodian)

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of McMahon Chiropractic & Physical Therapy.

I understand that the Notice describes the uses and disclosures of my protected health information by McMahon Chiropractic & Physical Therapy and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

3004 Golf Road, Suite 100 • Eau Claire, WI 54701 • Phone (715) 834-4516 • Fax (715) 834-0552

McMAHON
Chiropractic & Physical Therapy

Notice of Privacy Practices

Effective September 23, 2013

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

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

3004 Golf Road, Suite 100 • Eau Claire, WI 54701 • Phone (715) 834-4516 • Fax (715) 834-0552

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military

authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to be Notified of a Breach – You will be notified by us if we are informed that a breach of you PHI has occurred that could pose a significant risk to you. Such notification will include, to the extent possible, the circumstances of the breach, what PHI might have been compromised, the steps you can take to protect your interests, a brief description of what is being done to investigate the breach, mitigate the harm, and prevent further breaches. Notification will be done without unreasonable delay, and in no case later than 60 days following the discovery of a breach.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Kendra Albertson, designated Privacy Officer**

Address: McMahon Chiropractic & Physical Therapy, 3004 Golf Rd., Suite 100, Eau Claire WI 54701

Telephone No.: 715-834-4516

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____