Dr. Mackey's Family Chiropractic, PSC
Motor Vehicle Collision Questionnaire

Patient Name: ______________________________**Case #**_______________**Date:** ___________

Address_______________________________________ City______________State_______ Zip__________

H. Phone ________________________W. Phone_________________ Cell Phone ______________________

Email Address: ________________________

Sex M F   Marital Status M S D W   Date of Birth_______________   Age____________

Social Security #_______________________________________

Occupation____

Employer____

Have you ever received Chiropractic Care? Yes/No   If yes, when? ____________________________

Name of most recent Chiropractor:
____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
   ____
   ____
   ____
   ____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: ____
   B. Visual Disturbance : yes/no (please explain): ______________________________
   C. Dizziness: yes/no How often: ___________________________________
   D. Anxiety: yes/no How often: ___________________________________
   E. Depression: yes/no How often: ___________________________________
   F. Difficulty Sleeping: yes/no How often: ___________________________________

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3. **Past Health History:**

A. **Please indicate if you have a history of any of the following:**

□ Anticoagulant use
□ Bleeding problems
□ Cancer
□ Psychiatric disorders
□ Major depression
□ Stroke/TIA's
□ None of the above
□ Heart problems/high blood pressure/chest pain
□ Lung problems/shortness of breath
□ Diabetes □ type 1 □ type 2
□ Bipolar disorder
□ Schizophrenia
□ Other ___________

B. **Previous Injury or Trauma:**

____

Have you ever broken any bones? Which?

____

C. **Allergies:**

____

D. **Medications:**

Medication Name	Reason for taking	Dose	how often

E. **Surgeries:**

Date	Type of Surgery (if hysterectomy - with or w/o ovaries)

F. **Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome

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Dr. Mackey's Family Chiropractic, PSC
Motor Vehicle Collision Questionnaire

Patient Name: ________________________________**Case #**________________**Date:** ____________

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- □ Cancer
- □ Headaches
- □ Neurological diseases
- □ Cardiac disease below age 40
- □ Diabetes□ type 1 □ type 2
- □ Strokes/TIA's
- □ Cardiac disease
- □ Adopted/Unknown
- □ Psychiatric disease
- □ Other _______________
- □ None of the above

Deaths in immediate family:

____

Cause of parents or siblings death Age at death

____

____

____

____

____

5. Social and Occupational History:

A. Job description:

____

B. Work schedule:

____

C. Recreational activities:

____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

____

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Dr. Mackey's Family Chiropractic, PSC
Motor Vehicle Collision Questionnaire

Patient Name: ________________________________**Case #**________________**Date:** ____________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing □ COPD
□ Emphysema □ Other ____________
□ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Heart surgeries □ Congestive heart failure
□ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension
□ Pacemaker □ Angina/chest pain
□ Irregular heartbeat □ Other ___________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body
□ History of seizures □ Memory loss
□ Headaches □ Vertigo
□ Tremors □ Strokes/TIAs
□ Loss of sense of smell □ Other _______________
□ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy
□ Other ________________ □ Diabetes □ type 1 □ type 2
□ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine)
□ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease
□ Dialysis □ Other _______________________
□ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing
□ Ulcerative disease □ Frequent abdominal pain
□ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis
□ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence
□ Gastroesophageal reflux/heartburn □ Other __________________________
□ None of the above

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Review of Systems (continued)

Have you had any of the following **hematological (blood-related)** issues?

□ Anemia
□ HIV positive
□ Abnormal bleeding/bruising
□ Sickle-cell anemia
□ Enlarged lymph nodes
□ Hemophilia
□ Anticoagulant therapy
□ Other ________________
□ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ Hypercoagulation or deep venous thrombosis/history of blood clots
□ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns/grafts
□ Significant rashes
□ Other __________
□ Psoriatic disorders
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis/Osteoarthritis
□ Gout
□ Spinal fracture
□ Broken bones
□ Joint surgery
□ Spinal surgery
□ Scoliosis
□ Arthritis (unknown type)
□ Other _______________________
□ Metal implants
□ None of the above

Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis
□ Depression
□ Suicidal ideations
□ Bipolar disorder
□ Homicidal ideations
□ Schizophrenia
□ Psychiatric hospitalizations
□ Other _____________
□ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Gregg Friedman, DC, PLC/Arcadia Spinal Health Center for services performed.

Patient or Guardian Signature ____

Date_________________________

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Dr. Mackey's Family Chiropractic, PSC
Motor Vehicle Collision Questionnaire

Patient Name: ________________________________Case #________________Date: ____________

NEW PATIENT HISTORY FORM

Symptom 1 ____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): __________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 2 ____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? __________________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? ____
    - Did you have this symptom before this motor vehicle collision? Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, walking, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: ________________________________**Case #**________________**Date:** ____________

Symptom 3 ____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): __________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 4 ______________________________________ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _______________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _______________________________________
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _______________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Dr. Mackey's Family Chiropractic, PSC
Motor Vehicle Collision Questionnaire

Patient Name: ________________________________ **Case #**________________ **Date:** ____________

Symptom 5 ____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 6 ____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):
    - dull, achy, burning Sharp,, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _________________________________
- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? ____
    - Did you have this symptom before this motor vehicle collision? Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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Auto Accident Mechanism of Injury Form

Date of Collision: ______________________________ Hour of Accident: ___________________ AM / PM

Please describe how the collision happened: ____

____

____

____

____

ACCIDENT DESCRIPTION

1. Speed Limit: __________ mph
2. Speed of your vehicle when the accident occurred? ____________ mph
3. Traffic Conditions: Congested / Good / Heavy / Normal / Rush Hour
4. Vehicle Information:
   A. Angle of Impact: Front / Back / Left / Right / Other: ______________________________
   B. What type and year of vehicle were you in? ______________________________________
5. Did your vehicle travel off the road? Yes / No
6. Weather Conditions: Foggy / Normal / Poor Visibility / Raining / Snowing / Windy
7. Accident reported to Police? Yes / No
8. Were traffic citations issued? Yes / No If "YES", to whom? ___________________________
9. Was an injury/accident report filed? Yes / No
10. Status before accident (circle all that apply): Awake / Asleep / Seat reclined / Rotated in seat / Seat belt on / Shoulder harness on
11. Did you strike anything in the vehicle at the time of impact? Yes / No

    If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

12. Your position in the car: _____ Driver

    _____ Passenger Front / Mid / Back / Left / Center / Right

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ACCIDENT HISTORY

Capacities **before** the accident:

	Normal	Limited	Difficult	Painful
Bending				
Lifting				
Standing				
Walking				

Capacities **after** the accident:

	Normal	Limited	Difficult	Painful
Bending				
Lifting				
Standing				
Walking				

HOSPITALIZATION, LOCATION TAKEN AFTER THE ACCIDENT

Where did you go after the accident? Home / Hospital / E. R. / Minor Emergency Center

How did you get there? Ambulance / Police Car / Private Transportation / Other ______________

If to a hospital, when? ______________________________________

Were you admitted? Yes / No If "YES", how long? ____

POST INJURY

	Yes	No
Able to do mental work?		
Able to do physical work?		
Conscious after the accident?		
Remember the impact?		
Lost time from work?		
Limited in movement?		
Pain or discomfort?		
Riding in a car bothersome?		
Had outside help?		

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MISCELLANEOUS NOTES

If "Driver", were your hands on the steering wheel? Both / Left / Right

Did the airbags deploy? Yes / No

Did you strike another vehicle? Yes / No Did another vehicle strike your vehicle? Yes / No

If Second Collision – Angle of 2nd impact: Front / Back / Left / Right / Other: ________________

In relation to the back of your head, was your headrest set: Low / Middle / High

Were you surprised by the impact? Yes / No

If "NO", how did you brace? With Hands / With Feet

Where was your head facing at the time of impact? Straight Ahead / Left / Right / Behind

Were you leaning forward at the time of impact? Yes / No

What type and year of vehicle struck yours?____

What was the approximate speed of the other vehicle when the accident occurred? ________ mph

Did you feel pain immediately after the accident? Yes / No

Were you rendered unconscious as a result of the accident? Yes / No

Did your seat break or bend? Yes / No

Immediately following the accident, how did you feel? (Circle all that apply) Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other: ______________________________________

Police and Ambulance:

Name of Hospital? _________________________________ Attended by Dr. __________________

What treatment given? (Circle all that apply) None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other: __________________

What other doctor have you seen as a result of this injury? __________________________________

Do you have difficulty in excessive: Riding / Twisting

Symptoms other than above: ____

____ Patient Signature

______________________ Date

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Patient Name: ________________________________ **Case #**________________ **Date:** ____________

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work	Reason for the difficulty	Duration

Job Description: ____

Lifting	Increased Pain	____________________
Bending	Increased Pain	____________________
Sitting	Increased Pain	____________________
Walking	Increased Pain	____________________
Computer Duties	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Studies/School	Reason for the difficulty	Duration
Lifting	Increased Pain	____________________
Bending	Increased Pain	____________________
Sitting	Increased Pain	____________________
Walking	Increased Pain	____________________
Computer Duties	Increased Pain	____________________
Studying	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	____________________
Taking Care of Kids	Increased Anxiety	____________________
Cleaning	Increased Pain	____________________
Preparing Meals	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Household Duties	Reason for the difficulty	Duration
Yardwork	Increased Pain	____________________
Transportation	Increased Anxiety	____________________
Shopping	Increased Pain	____________________
Taking Out Trash	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

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Dr. Mackey's Family Chiropractic, PSC

Patient Name: ______________________________**Case #**_______________**Date:** ___________

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	Reason for the difficulty	Duration

Job Description: ____

Lifting	Increased Pain	____________________
Bending	Increased Pain	____________________
Sitting	Increased Pain	____________________
Walking	Increased Pain	____________________
Computer Duties	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Studies/School	Reason for the difficulty	Duration
Lifting	Increased Pain	____________________
Bending	Increased Pain	____________________
Sitting	Increased Pain	____________________
Walking	Increased Pain	____________________
Computer Duties	Increased Pain	____________________
Studying	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	____________________
Taking Care of Kids	Increased Anxiety	____________________
Cleaning	Increased Pain	____________________
Preparing Meals	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

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Dr. Mackey's Family Chiropractic, PSC

Patient Name: ________________________________ **Case #**________________ **Date:** ____________

Loss of Enjoyment (cont'd)

Household Duties	Reason for the difficulty	Duration
Yardwork	Increased Pain	____________________
Transportation	Increased Anxiety	____________________
Shopping	Increased Pain	____________________
Taking Out Trash	Increased Pain	____________________
Other: ____________	Increased Pain	____________________

Sports	Reason for the difficulty	Duration
Social	________________________	____________________
Competitive	________________________	____________________
Regional	________________________	____________________
Other:	________________________	____________________

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Patient Name: ________________________________ **Case #**________________ **Date:** ____________

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Patient Name: ______________________________ Case #_______________ Date: ___________

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the

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law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____________________________________ _________________________

Signature of Patient of Representative Date

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Printed Name

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