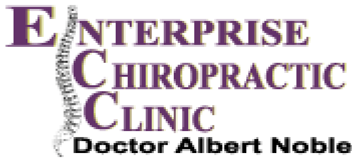


Initial Visit Form

GENERAL INFORMATION (all clients fill out)

Patient Information:

Last Name First Name MI	Today's Date
Street address (No PO Box)	How did you hear about us?
City State Zip	Social Security # Driver's License #
Home Phone	Sex Marital Status Date of Birth M F ☐ Single ☐ Married ☐ Div. ☐ Wid.
Work/Cell Phone	Emergency Contact Name/Phone #

Insurance Information:

Name of Insured Date of Birth	Date injury occurred (date of accident)
Your Relationship with Insured	Policy # Claim # / ID #
Insurance Company Name	Accident/Injury type (choose one) ☐ work (please explain):
Insurance Claims/Billing Address	☐ motor vehicle accident
City State Zip	☐ other (please explain):

MEDICAL HISTORY (all clients fill out)

1. When was your last physical exam? ____________ Who performed it? ________________________
   ☐ Do not recall when I had my last physical exam

2. Have you had any previous accidents/traumas/falls? **Yes/ No/ Do not recall** Date:_____________
   If yes, do you currently experience similar or different conditions? **Similar/Different**
   Explain any changes in intensity/frequency/duration of the pain you feel currently:_______________
   ____

3. Explain any previous hospitalizations: ____
   ☐ Do not recall any previous hospitalizations

4. Have you had any previous work-related injuries? **Yes/ No/ Do not recall** Date:_______________
   If yes, do you currently experience similar or different conditions? **Similar/Different**
   Explain any changes in intensity/frequency/duration of the pain you feel currently:_______________
   ____

5. List any medications you are currently taking and explain any side-effects: ☐ Not applicable
   ☐ Insulin ☐ Cortisone ☐ Nerve Pills ☐ Antidepressants ☐ Shoe lifts
   ☐ Blood pressure medication ☐ Vitamins/supplements
   ☐ Aspirin--How often? ____________ ☐ Pain killer/muscle relaxants
   List any known side effects: ____

Name: _________________________Date: ________________Claim Number: ____________________

6. Please list any allergies: ☐ none known ☐ dairy products ☐ eggs ☐ mold ☐ peanuts
   ☐ perfume ☐ pet dander ☐ poison ivy ☐ pollen ☐ smoke ☐ strawberries
   ☐ wheat ☐ other—Please explain: ______________________________________

7. Have you had any surgeries? **Yes/ No/ Do not recall**
   What type(s) and date(s)? ____

8. Please check all that apply. ☐ use alcohol ☐ use tobacco ☐ use caffeine ☐ use alternative medicine
   ☐ exercise regularly ☐ have good sleep habits ☐ have a well-balanced diet
   ☐ eat low salt/fat diet ☐ experiencing stress at home/work
   Include any explanation you feel necessary:____

CHIEF COMPLAINT (all clients fill out)
Note: Ranking 1-10 key: 1-4=mild, uncomfortable; 5-7= distressing; 8-10= intense, unbearable

A. Check all that apply. Do you experience:
☐ **Neck pain-** Where: ☐ shoots into upper back on right side ☐ shoots into upper back on left side
☐ upper/lower ☐ more right sided ☐ more left sided ☐other:_________________
Intensity: (rank 1-10):_______ Comments:____

☐ **Headaches-** Where:☐ whole head ☐ forehead ☐ back of head ☐ behind eye ☐ temple ☐ right side
☐ left side ☐ other:____
Intensity: (rank 1-10):_______ Comments:____

☐ **Mid back pain-** Where: ☐ whole mid back ☐ more right sided ☐ more left sided
☐ shooting around chest ☐ other:__________________________________
Intensity: (rank 1-10):_______ Comments:____

☐ **Low back pain-** Where: ☐ whole low back ☐ more right sided ☐ more left sided
☐ shoots into right/left leg ☐ other:________________________________
Intensity: (rank 1-10):_______Comments:____

☐ **Other:**________________- Where specifically:____
Intensity: (rank 1-10):_______Comments:____

B. Do you have bowl or bladder problems: **Yes/ No**

C. Do you feel pain in the: ☐ right arm ☐ left arm ☐ right leg ☐ left leg ☐ankles ☐ knee ☐ hips
☐ not applicable

D. Do you feel: ☐ numbness or tingling in the legs and/or feet ☐ loss of balance
☐ numbness or tingling in the arms ☐ not applicable

E. Describe any additional information regarding your condition:
____

Name: ________________________Date: _______________Claim Number: ___________________

F. Possible jaw pain symptoms. Check all that apply:
☐ ear pain, ache, itch, sharp pain ☐ ringing in the ear ☐ dizziness ☐ teeth problems
☐ face numbness ☐ grind teeth at night ☐ jaw joint pain or clicking ☐ ear fullness, plugged
☐ other experienced TMJ related symptoms not listed: ____________________________
☐ not applicable

G. Possible foot/leg related symptoms. Check all that apply:
☐ deep knee pain ☐ knee pain ☐ foot pain ☐ foot numbness at bottom of foot
☐ hip pain ☐ low back pain ☐ pelvic pain ☐ whole leg pain
☐ other experienced TMJ related symptoms not listed: ____________________________
☐ not applicable

H. Possible brain and brainstem related symptoms. Check all that apply:
☐ problems w/ long or short term memory ☐concentration problems ☐aggravation by noise
☐ anxiety ☐ depression ☐ irritability ☐ sleep problems ☐ sex problems ☐fatigue
☐ change in smell or taste ☐ other-please explain: ____________________________
☐ not applicable

I. How long/regularly do you experience the pain?
☐ all the time ☐ during the day ☐ during the night ☐ more than 6 hours ☐ less than 1 hour
☐ in intervals--How long each time? __________________________
☐ other--Please explain: ___________________________________

J. What makes the symptoms better?
☐ aspirin ☐ movement—In what direction: _________________________
☐ heat ☐ ice ☐ massage ☐ muscle relaxants ☐ rest
☐ stretching ☐ bed rest ☐ elevation ☐ nothing
☐ other--Please explain: ____

K. Describe any activities that make symptoms worse:
____

L. How and when did the pain begin: ___________________________________

M. Did the accident/injury/incidence of pain occur more than two weeks ago? **Yes/No**
If yes, please explain why you did not come in before two weeks:_______________
____

PHYSICAL EXAMINATION (Dr. Noble or Assistant complete)

Height: ___________ Weight: ___________B.P. ____/____Pulse: ___________

Name: ________________________Date: _______________Claim Number: ___________________

CONSENT TO TREAT & FINANCIAL AGREEMENT (*Please read and sign*)

I hereby authorize the Doctor to treat my condition/the condition of my child or legal ward (***please circle***) as he deems appropriate.

The primary treatment used by the Doctor is spinal manipulative therapy; this will be used for treatment. Hands or a mechanical instrument may be used upon my body in such a way as to move my joints. That may cause an audible "pop" or "click," and I may feel a sense of movement. Other treatment options include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers, hospitalization, and surgery. If one of these "other treatment" options is chosen, I am aware that there are risks and benefits of such options and that I may want to discuss these with my primary care physician.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered to me and that this agreement is made solely for the Clinic's additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I authorize my insurance company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

We will call to verify eligibility and benefits as a courtesy to our patients. As the insurance policy is a contract between the patient and the insurance company we cannot guarantee these benefits. Any amount that the insurance company does not cover becomes the responsibility of the patient, regardless of any reduction, denials or arbitrary determination of usual and customary fees. We advise our patients to verify their own insurance.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Noble and have had my questions answered to my satisfaction. By signing below I state I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

I have also read, understand, and agree to the financial agreement stated above.

________________________ ____
Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

________________________ ____
Date Witness' Signature

OUR CANCELATION POLICY & OFFICE NOTICE

An appointment is a commitment by yourself and the doctor to set aside time to treat you. Therefore, we request that our patients notify us at least 24 hours in advance when canceling or rescheduling an appointment so that we may make the appointment available to those who need it.

We reserve the right to charge a Missed Appointment Fee of $25.00 to those patients who miss their appointment without notifying us, or who cancel/ reschedule an appointment with less than 24-hour notice. This fee is not covered by insurance and will need to be paid by the patient.

So as not to inconvenience those who arrive at their appointed time, late comers may receive shortened treatment at the regular treatment fee. Those who arrive for their scheduled appointments will be served first.

Also, we are not responsible for lost or stolen personal items. We are not responsible for your children or any children that might be with you during your visit. We are not responsible for any injuries that occur at home from doing exercises the doctor gives you.

We value your business and strive to ensure that we are always available to you when you need us. Thank you.

I understand and agree to the above:

____
Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _______________________ (your name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Enterprise Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created , received or maintained by the Practice.

____
Signature Date

____
Print Name

For Office Use Only

The Practice has made a good-faith effort to obtain an acknowledgement of _______________________'s receipt of our Notice of Privacy Practices. In an effort to obtain it, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner: ☐ Personally ☐ Mail ☐ Phone Follow-up ☐ Other ____

In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons: ☐ Patient unavailable ☐ Patient physically unable ☐ Patient unwilling. Signature/Date____

Name: _________________________Date: _______________Claim Number: ____________________

WORK RELATED INJURY INFORMATION (Workers Comp. clients only)

1. Date of work related injury:__________________

2. Who was your employer at the moment of the incident? ______________________________________
   Your occupation:____________________ Job description:___________________________________
   Address:____
   City/State/Zip:____
   Phone #:_________________________ Name of supervisor(s):______________________________

3. Describe what happened during the incident:____
   ____
   ____
   ____

4. Was your body hit? **YES/ No** Where?____

5. Where you lifting anything? **Yes/ No** How much did it weigh?_________________________________
   If yes, did you lift properly with your legs, keep your back straight? **Yes/ No**

6. How was your body positioned at the time of the incident?
   ☐ standing ☐twisting at waist ☐ lifting with back straight ☐bent over
   ☐ stationary ☐ moving ☐ in a vehicle ☐ sitting
   ☐ other-please specify: ____

7. Was this activity **out of the ordinary** or a **regular work-related** activity? (circle one)

8. Additional incident information:____
   ____
   ____

9. As a result of the accident were you: ☐ shaken but able to keep working
   ☐ unable to move certain body parts--Please explain what parts and why: ___________________________
   ☐ bruised or bleeding (please describe injuries) ____
   ☐ not able to continue working ☐ not able to move properly due to pain and needed assistance
   ☐ vague about what happened. ☐ other:____

10. Did you inform your supervisor about the incident? **Yes/ No**
    If yes, how soon after the incident? ____

11. Did your supervisor report the injury? **Yes/No**

12. Did your supervisor give you any paperwork and/or claim number regarding the injury? **Yes/No**
    If yes, what information did he give you (i.e. claim number or type of paperwork):___________________
    ____

13. Do you recall hitting your head? ☐do not recall if I did or did not hit my head
    ☐Yes, I recall hitting my head ☐No, I did not hit my head

Name: ________________________ Date: _______________ Claim Number: ___________________

Following the accident:

14. Since the incident, have you returned to work? **Yes/ No** If yes, when did you return?________________

15. Dates through which you did not work due to the injury?______________________________________

16. Since the injury, can you work regular shifts with no pain? **Yes/No**

17. Were you taken to a hospital emergency room? **Yes/No**
    If yes, hospital name: _________What areas were check/treated? ______________________________

18. Did you make follow-up treatments for the injuries? **Yes/No**
    If yes, what hospital? ____

19. Were X-rays taken? **Yes/No** If yes, what body parts? ____
    By whom? _______________________

20. Did you suffer from any conditions other than the symptoms already listed that arose after the accident? **Y/N**
    If yes, please explain: ____

21. Have you retained an attorney to represent you for this accident? **Yes/No**
    If yes, please provide the following for our records:
    Attorney's Name: __________________________________ Phone # ___________________________
    Attorney's Address: ____
    City/State/Zip:____

Name: _________________________Date: ________________Claim Number: ____________________

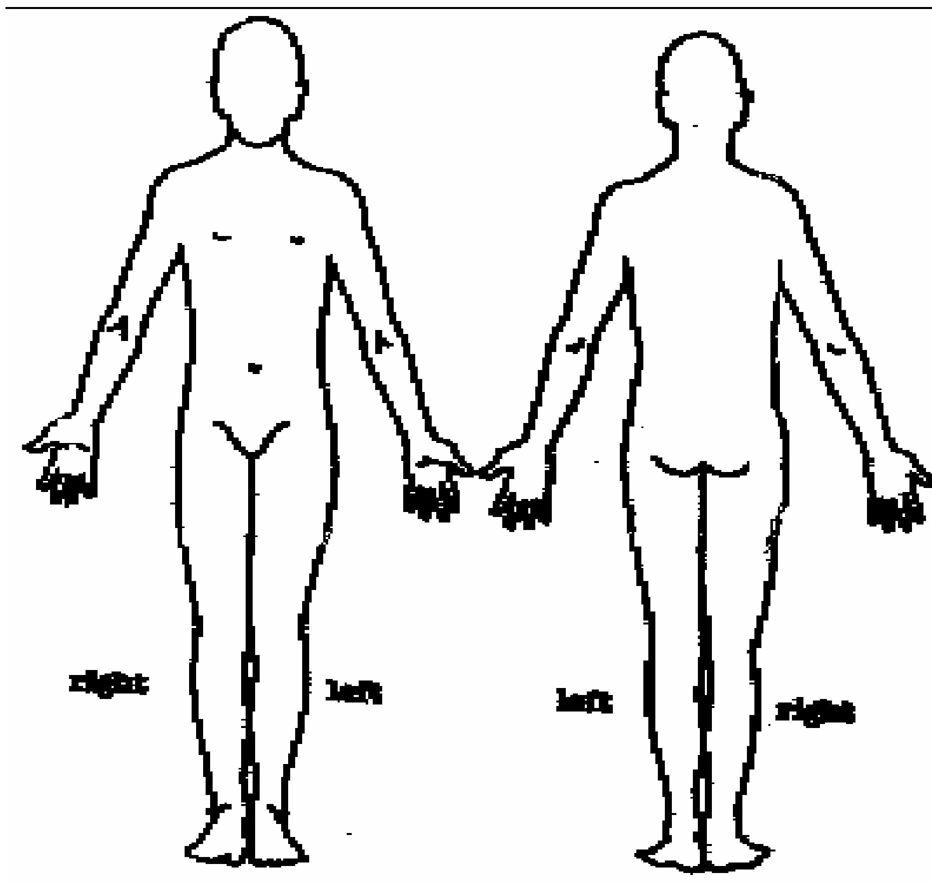
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- -	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	x x x x x x x x x x x x x x x x x x	* * * * * * * * * * * * * * * * * *	/ /

Please mark the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_________________________)
0 10
No pain Severe pain

Mid Back Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_________________________)
0 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_________________________)
0 10
No pain Severe pain

DATE:_________________ SIGNATURE:_________________________________

SYSTEMS REVIEW

NAME:____ DATE:_________________ FILE #:__________________

Please review the following list of conditions. If you have had a condition in the ***Past***, check column 1. If you have a condition ***Now***, check Column 2.

Past	Now		GENERAL
		784	Headaches
		780.6	Fever
		780.9	Chills
		780.8	Night Sweats
		780.2	Fainting
		780.4	Dizziness
		780.3	Convulsions
		780.52	Loss of Sleep
		780.7	Fatigue
		799.2	Nervousness
		783	Weight Loss
		782	Pain/Numb Limbs
		995.3	allergy
		786.09	Wheezing
		729.2	Neuralgia

Past	Now		EYE, EAR, NOSE, THROAT
		368.9	Poor Vision
		378.9	Crossed eyes
		379.91	Pain in eyes
		689.9	Deafness
		388.7	Earache
		388.3	Ear Noises
		388.6	Ear Discharges
		478.1	Nasal Obstruction
		784.7	Nose Bleeds
		462	Sore Throat
		784.49	Hoarseness
		477.9	Hay Fever
		793.9	Asthma
		460	Frequent Colds
		240.9	Enlarged Thyroid
		463	Tonsillitis
		686.9	Sinus Troubles

Past	Now		CARDIO-VASCULAR
		783	Rapid Heart
		427.89	Slow Heart
		401.9	High Blood Pressure
		458.9	Low Blood Pressure
		786.51	Pain over Heart
		438	Heart Trouble
		719.07	Ankle Swelling
		459.9	Poor Circulation
			Varicose Veins
		436	Strokes

Past	Now		GENITAL-URNIARY
		788.3	Frequent Urination
		788.1	Pain during Urination
		599.7	Blood in Urine
		592	Kidney Infection
		788.3	Bed Wetting
		788.1	Can't Control Urination

Past	Now		GASTRO-INTESTINAL
		783	Poor Appetite
		536.8	Poor Digestion
		994.2	Excessive Hungary
		787.3	Belching or Gas
		787	Nausea
		787	Vomiting
		578	Vomiting Blood
		536.8	Pain over stomach
		564	Constipation
		558.9	Diarrhea
		789	Colon Trebles
		455.6	Hemorrhoids/Piles
		785.1	Liver Trouble
		782.4	Jaundice
		575.98	Gall Bladder Trouble

Past	Now		FOR WOMEN ONLY
		786.2	Painful Periods
		626.2	Excessive Flow
		626.4	Irregular Cycles
		627.2	Hot Flashes
		625.3	Cramps/Backache
		634.6	Miscarriage
		623.5	Vaginal Discharge
			Pregnancy

Last Pap Date:________________________

Start Date of last Period:____________

Past	Now		MUSCLE & JOINTS
			Weakness
			Twitching
		847	Stiff Neck
		722.1	Backache
		719	Swollen Joints
		781	Tremors
		729.5	Foot Troubles
		724.79	Painful Tail Bone
		724.5	Pain between shoulders
		553.9	Hernia
		737.3	Spinal Curvature

Past	Now		SKIN OR ALLERGIES
		368.9	Skin Eruptions
		698.9	Itching
		287.8	Bruise Easily
		701.1	Dryness
			Boils
		782	Sensitive Skin
		708.9	Hives/Allergy
		692.9	Eczema
			Medicines

Enterprise Chiropractic Clinic
Dr. Noble
Phone
Fax

9900 SW Greenburg Rd. # 225
Tigard, OR 97223
(503) 624-0416
(503) 639-2052

10756 SE Washington St.
Portland, OR 97213
(503) 252-5320
(503) 252-1374

SYSTEMS REVIEW

NAME:____ DATE:_________________ FILE #:__________________

Please review the following list of conditions. If you have had a condition in the Past, check column 1. If you have a condition Now, check Column 2.

Past	Now	NA	HABITS	Past	Now		RESPIRATORY
			Smoking______packs/day			786.2	Chronic Cough
			Alcohol______drinks/day			766.3	Spitting Blood
			Coffee_______cups/day			933.1	Spitting Phlegm
			No Exercise			786.5	Chest Pain
			Moderate Exercise			786.09	Difficulty Breathing
			Daily Exercise				

FAMILY HISTORY				Diabetes	Heart	Kidney	Cancer	Back	NONE
Mother		Living	Deceased						
Father		Living	Deceased						
Brothers			How Many? __________						
Sisters			How Many? __________						

CHECK ANY DISEASE YOU HAVE HAD:

	Code	Disease		Code	Disease
	541	Appendicitis		285.9	Anemia
	541	Pneumonia		285.9	Measles
	541	Rheumatic Fever		285.9	Mumps
	541	Polio		285.9	Chicken Pox
	541	Tuberculosis		285.9	Diabetes
	541	Whooping Cough		285.9	Cancer
	429.9	Heart Disease		716.9	Arthritis
	429.9	Goiter		716.9	Epilepsy
	429.9	Influenza		716.9	Mental Disorder
	429.9	Pleurisy		716.9	Lumbago
	429.9	Alcoholism		716.9	Eczema
	429.9	Venereal Disease			

LIST ANY ALLERGIES YOU HAVE:

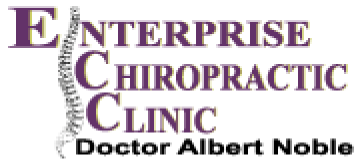
____

____

____

____

____



IRREVOCABLE DOCTOR'S LEIN AND ASSIGNEMNT OF RIGHT TO RECOVERY

Name: ________________________Date: _______________Claim Number: ___________________

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctor on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about _______________ , to the full extent of the cost and treatment provided or to be provided me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any given, grant and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of injuries or conditions for which I have been treated by the Clinic.

If no attorney is trusted with my case, I understand that the insurance will directly pay the clinic for all services rendered as a result of this accident and any other bills that are due.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic *is not* responsible for paying any of my attorneys' fees and the Clinic *does not* agree to pay my attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY *NOT* REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.

______________________________ ___________________________ ________________

Print Patient Name Patient Signature Date

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Oregon Revised Statute 192.525, 1997

Name: ________________________Date: _______________Claim Number: ___________________

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize_____________________________(name of hospital/health care provider) to release a copy of the medical information for_________________________(name of patient) to Enterprise Chiropractic Clinic, 9900 SW Greenburg Rd. Suite 225, Tigard, OR 97233(name and address of recipient).

The information will be used on my behalf for the following purpose(s):
____
____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:
____All hospital records (including nursing records and progress notes)
____Transcribed hospital reports
____Medical records needed for continuity of care
____Most recent five year history
____Laboratory reports
____Pathology reports
____Diagnostic imaging reports
____Clinician office chart notes
____Dental records
____Physical therapy records
____Emergency and Urgency care records
____Billing statements
____Other

____Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

____*HIV/AIDS-related records
____*Mental Health information
____*Genetic testing information ______________ *Must be initialed to be included in other documents.
____**Drug/alcohol diagnosis, treatment or referral information: **Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

____This authorization is limited to the following treatment:
____
____This authorization is limited to the following time period:
____
____This authorization is limited to a worker's compensation claim for injuries of
_______________(date)/

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_________________________ ____
(Date) (Signature of Patient)

_________________________ ____
(Date) (Signature of person authorized by law)

Name: ________________________ **Date:** _______________ **Claim Number:** __________________

PATIENTS COPY

ENTERPRISE CHIROPRACTIC
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 effective as of 04/15/03, 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:

A. TREATMENT, PAYMENT, and HEALTH CARE 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 health care operations. Examples of these activities are as follows:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to 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 health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to 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 use or disclose your health information for any reason except those permitted by this Notice.

Name: _________________________Date: ________________Claim Number: ____________________

C. 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 with 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 a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES 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 that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary at avert a serious threat to your health or safety or the health or safety of others.

G. 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 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 national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. 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. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you $0.25 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 for 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.

Name: ________________________Date: _______________Claim Number: ___________________

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates 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.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. 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.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

QUESTIONS AND COMPLAINTS:
If you want more information about our privacy practices or have questions on concerns, please contact us.

If your are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

CONTACT: Dr. Albert Noble, Enterprise Chiropractic Clinic
FAX: 503-639-2052
E-MAIL: info@drnoble.net