Alpha Family Chiropractors
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 CARFULLY.

Alpha Family Chiropractors is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health care information

Treatment

We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Alpha Family Chiropractors."

'It is our policy to provide a substitute health care provider, authorized by Alpha Family Chiropractors to provide assessment and/or treatment to our patients, without advance notice in the event your primary health care provides absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)
"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Alpha Family Chiropractors for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services received.

Workers' Compensation
We may discuss your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying an immediate family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities to purpose related to: Preventing or controlling a disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and infection exposure

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding with prior written notice to patient if permitted by law.

Law Enforcement
We may disclose your health information to a law enforcement official for purpose such as identifying or location a suspect, fugitive, material witness or missing person, complying with a court or subpoena, and other law enforcement purpose.

Public Safety

It may be necessary to disclose our health information to appropriate person in order to present or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purpose.

Home Contact
We may contact your for scheduling purposes, as described below(example)

"As a courtesy to our patients, it is our policy to call you home after missing your scheduled appointment to remind you of your missed appointment time. If you are not home, we leave a reminder message on your answering machine or with a person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"We may send you a letter or post card. It is not our policy to disclose any personal health information about your condition for the purpose of Alpha Family Chiropractors sponsored fundraising events."

Change of Ownership

In the event that Alpha Family Chiropractors is sold or merged with another organization, your health information/record will become the property of the new owner in the chiropractic profession.

Your Health Information Rights.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Alpha Family Chiropractors is not required to agree to the restriction that your requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information
- You have the right to request that Alpha Family Chiropractors amend your protected health information. Please be advises, however, that Alpha Family Chiropractors is not required to agree to amend you protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Alpha Family Chiropractors.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Alpha Family Chiropractors reserves the right to amend this notice of Privacy at any time in the future, and will make the new provisions effective for all information that is maintains. Until such amendment is made, Alpha Family Chiropractors is required by law to comply with this notice.

Alpha Family Chiropractors is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or you want more information about your privacy rights, please contact, Dr. Lori Portnoy by calling our office at 773-248-2323. If Dr. Lori Portnoy is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

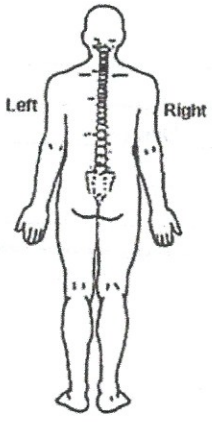
DHHS, Office of Civil Rights
200 Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201

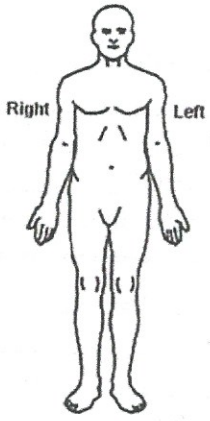
Confidential Patient Information

Today's Date: _____ Name, Last: _____ First: _____
Permanent Mailing Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Marital Status: Sg___M___D___Sp___W___ Number of Children: ___ Pregnant? _____
Home #: (____) _____-_____ Cell #: (_____) _____-_____ Work#: (_____) _____-_____
Birthdate: ____/____/____ Age: _____ Race: _____ Social Security #_____-_____-_____
How did you hear about our office? _____
Employer: _____ Occupation: _____

When did you symptom(s) begin? _____
Was it Gradual_____ or Sudden_____?
Is your symptom improved (I) or Worsened (W) or Unchanged (U) by the following activities:
Sitting ____ Cough/Sneeze ____ Twisting ____ Standing ____ Inactivity ____ Laying Down ____
Bending ____ Other Improves _____ Other Worsens _____
Is your symptom: Sharp _____ dull _____ Burning _____ Throbbing _____
Does the pain radiate? Y_____ N _____ Where? _____
Is your pain: Zero _____ Mild _____ Moderate _____ Considerable _____ Severe_____
Is your symptom improved (I) Worsened (W) or Unchanged (U) in the:
Morning _____ Afternoon _____ Evening _____ Night _____
What is your condition interfering with? Work _____ Family Life _____ Relationships _____
Recreation _____ What Activities/Hobbies _____
Any recent stress that may be contributing to your condition? _____
_____

Please circle the exact location of any pain you are experiencing. Then describe the type of pain.





In order of importance, list the health problems you are most interested in getting Corrected.

1)_____
2)_____
3)_____

In order of severity, list those body functions That you are unable to perform, or that produce pain.

1) _____
2) _____
3) _____

Date:_____ Name: Last, _____ First: _____

Have you received Chiropractic care before? No ____ Yes_____ Where? _____

When was your last treatment? _____ What were you treated for? _____

List any Doctor's you have seen or tests you have had for this condition (dates & treatment) _____

_____

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

_____

Are you presently taking any medications? No _____ Yes _____ What?_____

_____

List any accidents or falls and dates (car accidents, sports injuries, slips & falls, etc.): _____

_____

List any broken bones (fractures) or dislocations & dates: _____

_____

Have you ever had a spinal injection? No _____ Yes _____ When _____

What diseases have you suffered from? _____

List any past operations & dates: _____

List relevant major health problems of immediate relatives: _____

_____

Deaths in immediate family: (cause and age) _____

_____

Please give most current dates:

Spinal Exam: _____

Spinal X-Rays: _____

MRI: _____

Blood Tests: _____

Last Physical: _____

Females Only:

Pap Smear: _____

Breast Exam: _____

Males Only:

Prostate Exam: _____

Sports/Exercise you currently do:

Type:	How Often:
_____	_____
_____	_____
_____	_____

Typical Work Activities: _____

_____

Hours you: Sit _____ Stand _____ Drive _____

Maximum you lift? _____

Your normal work days & hours: _____

Does your pain wake you up at night? No _____ Yes _____

Are you currently losing weight? No _____ Yes _____

Are you coughing up blood or blood in your stool? No _____ Yes _____

Any loss of bowel or bladder control? No _____ Yes _____

Any loss of consciousness, or double vision? No _____ Yes _____

Do you smoke? No _____ Yes _____ How Often? _____ _____

Do you drink alcohol? No ____Yes ____ How Often? _____

Caffeine? How often? _____ How Much? _____

Signature: _____ Date: _____

Authorization To Bill Health Insurance/Assignment of Benefits

I _____ (print name) do hereby give full permission and authorize Alpha Family Chiropractic, to bill _____(name of insurance company) for services rendered by Alpha Family Chiropractic. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Alpha Family Chiropractic
954 W Armitage Ave
Chicago, IL 60614

By signing this document I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Alpha Family Chiropractic, for correct billing. I am also responsible to notify Alpha Family Chiropractic in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that Alpha Family Chiropractic will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Alpha Family Chiropractic during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Alpha Family Chiropractic, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of Alpha Family Chiropractic requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Alpha Family Chiropractic of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____
Patient's Signature Date

_____ _____
Representative of Alpha Family Chiropractic Date

Alpha Family Chiropractors
Notice of Privacy Practices

This notice is effective as of ____/____/____

I have read the privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Alpha Family Chiropractors with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patients Name (print)

_____ _____
Patients Signature Date

_____ _____
Authorized Facility Signature Date