



CONFIDENTIAL PATIENT INFORMATION

Name: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Phone Carrier: _____

Best telephone number to reach you during the day: Cell Work Other: _____

Email: _____ Age: ____ DOB: _____ Height: ____ Weight: ____ Male/Female

Marital Status: S M W D How many children: ____ Names, Ages & Gender: _____

Occupation: _____ Employer: _____ Phone: _____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Who may we thank for referring you in? FACEBOOK, INSTAGRAM, OTHER: _____

Health History

Main symptom you feel: _____ Average Pain Level: 0-10 (10 being worst) _____

Quality of Pain: Aching Burning Deep Dull Heavy Intolerable Pulling Sharp Shock like

Stabbing Stiffness Throbbing Tightness Tingling

What caused your condition: Auto Accident Work Accident Overexertion, Lifting, Pulling, Etc.

Repetitive Movement/Posture Fall/Slip/Trip Gradual Onset Other: _____

DOI: _____ Date symptom appeared: _____ Is symptom: Better Worse Same

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Evaluation: _____ Member ID: _____

Health Concerns: List Worst First	Rate Severity 1=Mild 10=Unbearable	When did this episode start?	Did you have the condition before? when?	Did the problem begin with an injury?	Constant or Intermittent?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE – CANCER – HEART DISEASE – SPINAL SURGERY – SPINAL FRACTURE – SCOLIOSIS – DIABETES

Have you seen any other doctors for this condition?

Chiropractor Medical Doctor Other

If so, Who & When: _____



List Surgeries and Date: _____

List all MEDICATIONS you are currently taking: _____

When was your last AUTO ACCIDENT? _____

Have you had previous chiropractic care? YES NO If YES, When & Who: _____

Have you ever been knocked unconscious? YES NO

Fractured any bones? YES NO If YES, Please describe _____

Any other bodily trauma? _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

- | | | | |
|-------------------|-------------------|-------------------|-----------------|
| DIZZINESS | ASTHMA | KIDNEY PROBLEMS | CHRONIC FATIGUE |
| HEADACHES | ULCERS | BLADDER PROBLEMS | LUPUS |
| VERTIGO | CHEST PAINS | IRRITABLE BLADDER | FYBROMYALGIA |
| EAR INFECTIONS | ARM NUMBNESS | SCIATICA | ADD / ADHD |
| GRATING OF NECK | ARM PAIN | LEG NUMBNESS | GERD |
| TMJ | HAND NUMBNESS | FEET NUMBNESS | ANXIETY |
| NECK PAIN | SHOULDER PAIN | LOW BACK PAIN | NERVOUSNESS |
| MIGRAINES | HEART DISORDERS | HIP PAIN | EPILEPSY |
| STIFFNESS IN NECK | MID BACK PAIN | LEG PAINS | DISC PROBLEMS |
| CHRONIC SINUS | STOMACH DISORDERS | KNEE PAIN | INFERTILITY |
| THROAT ISSUES | NAUSEA | LIVER DISEASE | OTHER _____ |
| THYROID ISSUES | REFLUX | MENSTRUAL ISSUES | _____ |
| ANXIETY | DEPRESSION | ADDICTION | |

The information I have provided is accurate and I know it will be used to determine appropriate chiropractic care. I authorize the performance of X-rays and all of their diagnostic and therapeutic procedures for myself and/or for my dependent(s). I acknowledge receipt of the Notice of Privacy Practices. I also give my consent to receive important email correspondence from this office.

Signature of responsible party: _____ Date: _____



Circle **ONLY ONE POINT VALUE** for the question in each section that most applies to your situation.

Section	Questions	Pain
My pain at this moment	None	0
	Mild	1
	Moderate	2
	Severe	3
	Very Severe	4
	Worst Imaginable	5
Looking after Myself currently	Normal without extra pain	0
	Normal but with some pain	1
	Painful and slow	2
	Need help but manage mostly	3
	Need help with most of it	4
	Cannot do much and stay in bed	5
Lifting weight right now	Heavy weight without pain	0
	Heavy weight but some pain	1
	No heavy weights unless positioned conveniently	2
	Light to medium weight if positioned conveniently	3
	Only very light weight	4
	None what so ever	5
Reading for me	No pain no matter how long	0
	Mild pain no matter how long	1
	Moderate pain no matter how long	2
	Difficult due to moderate pain	3
	Difficult due to severe pain	4
	Not possible right now	5
Pain with headaches	None	0
	Slight and infrequent	1
	Moderate and infrequent	2
	Moderate and frequent	3
	Severe and frequent	4
	Most or all of the time	5
My ability to concentrate	Full with no difficulty	0
	Full with slight difficulty	1
	Fair degree of difficulty	2
	A lot of difficulty	3
	Great degree of difficulty	4
	Not able at all	5
Performing my usual work	Easy to do as much as I want	0
	Can do but no more	1
	Can do mostly but no more	2
	Hardly can do	3
	Cannot do	4
	Cannot do any work	5
Driving my car	Easy and without pain	0
	As long as I want with only slight pain	1
	As long as I want with moderate pain	2
	Cannot do long because of pain	3
	Hardly do because of severe pain	4
	Cannot do at all	5
Sleeping for me	No trouble at all	0
	Slightly disturbed (less than 1 hour sleepless)	1
	Mildly disturbed (1-2 hours sleepless)	2
	Moderately disturbed (2-3 hours sleepless)	3
	Greatly disturbed (3-5 hours sleepless)	4
	Completely disturbed	5
My recreational activities	Cause no pain	0
	Cause some pain	1
	Cannot do all of them because of pain	2
	Can only do a few of them because of pain	3
	Can hardly do any of them because of pain	4
	Cannot do any at all	5

Oswestry Pain & Disability Index

Name: _____ Date: _____

OFFICE USE ONLY: Points _____ % _____

Circle ALL levels you are experiencing any symptoms listed.

	SYMPTOMS	INNERVATION
C1	HEADACHES, MIGRAINES, POOR METABOLISM, NERVOUSNESS, HYPERACTIVITY, INSOMNIA, CHRONIC FATIGUE, DIZZINESS, IMMUNITY	SYMPATHETIC NERVOUS SYSTEM, BRAIN, PITUITARY GLAND, INNER/MIDDLE EAR, BLOOD SUPPLY TO HEAD, SINUSES
C2	SINUS TROUBLE, ALLERGIES, PAIN AROUND EYES, EAR ACHES, DEAFNESS, BLINDNESS, CROSSED EYES, FAINTING	AUDITORY NERVE, OPTIC NERVE, TONGUE, SINUSES
C3	ACNE, PAIN OR LOSS OF SENSATION IN THE FACE	TRIGEMINAL NERVE, OUTER EAR, CHEEKS, TEETH
C4	WATERY EYES, RUNNY NOSE, HEARING LOSS	EAUSTACHIAN TUBE, MOUTH, NOSE, LIPS, ADENOIDS, MUCOUS MEMBRANES
C5	LARYNGITIS, HOARSENESS, THROAT PROBLEMS	PHARYNX, LARYNX, VOCAL CORDS
C6	NECK STIFFNESS, SHOULDER PAIN, TONSILLITIS, CROUP	NECK AND SHOULDER MUSCLES, TONSILS
C7	ARM/HAND PAIN, NUMBNESS OR TINGLING, THYROID CONDITIONS, POOR WEIGHT REGULATION, SLUGGISHNESS, NERVOUSNESS	THYROID GLAND, ARMS, HANDS
T1	DIFFICULTY BREATHING, SHORTNESS OF BREATH, ASTHMA, CHRONIC COUGH	ESPHAGUS, TRACHEA, HEART, FOREARMS, HANDS
T2	HEART CONDITIONS	HEART, CORONARY ARTERIES, LUNGS
T3	BRONCHITIS, PLEURISY, PNEUMONIA, INFLUENZA, CONGESTION	BREASTS, LUNGS, BRONCHI, HEART
T4	GALLBLADDER PROBLEMS, JAUNDICE	GALLBLADDER, HEART, LUNGS
T5	LIVER PROBLEMS, FEVERS, BLOOD PRESSURE PROBLEMS, POOR CIRCULATION, ARTHRITIS	ESOPHAGUS, GALLBLADDER, LIVER, HEART
T6	STOMACH PROBLEMS, NERVOUS STOMACH, INDIGESTION, HEARTBURN, DYPEPSIA	STOMACH, ESOPHAGUS, DUODENUM
T7	IRREGULAR CARBOHYDRATE METABOLISM, ULCERS, GASTRITIS, MID-BACK-PAIN	PANCREAS, DUODENUM, SPLEEN
T8	IMMUNITY ISSUES	SPLEEN, PANCREAS, ADREANAL GLANDS, DIAPHRAGM
T9	POOR SYMPATHETIC RESPONSE, POOR METABOLISM	ADRENAL GLANDS, SPLEEN, PANCREAS, OVARIES, UTERUS
T10	KIDNEY PROBLEMS, HARDENING OF THE ARTERIES, CHRONIC FATIGUE, NEPHRITIS, PHYLITIS	KIDNEYS, SPLEEN, PANCREAS, OVARIES, UTERUS, BLADDER
T11	ACHNE, PIMPLES, ECZEMA OR BOILS	KIDNEYS, OVARIES, UTERUS, BLADDER
T12	RHEUMATISM, GAS PAINS	SMALL INTESTINES, BLADDER, UTERUS
L1	CONSTIPATION, COLITIS, IRRITABLE BOWEL, DIARRHEA, HERNIAS	LARGE INTESTINES
L2	CRAMPS, DIFFICULTY BREATHING	ABDOMEN, APPENDIX, CECUM, BLADDER, UPPER LEG
L3	BLADDER TROUBLE, MENSTRUAL TROUBLE, MISCARRIAGES, BEDWETTING, IMPOTENCY	BLADDER, GENITALIA, PROSTATE
L4	SCIATICA, LOW-BACK PAIN, DIFICULT PAINFUL OR FREQUENT URINATION	SCIATIC NERVE, MUSCLES OF LOWER BACK, PROSTATE
L5	LEG/FOOT PAIN NUMBNESS OR TINGLING, POOR LEG CIRCULATION, SWOLLEN ANKLES, COLD FEET, LEG CRAMPS	LOWER LEG, SCIATIC NERVE, ANKLES, FEET, TOES, PROSTATE
S	SACRO-ILIAC CONDITIONS, SPINAL CURVATURES	BUTTOCKS, FASCIA OF HIP, BLADDER, PROSTATE, SCIATIC NERVE
C	HEMORRHOIDS, PRURITUS, LOW-BACK PAIN	RECTUM, ANUS



REVIEW OF SYSTEMS

First Name	Initial	Last Name	Date
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GENERAL	NOW	PAST	EYES	NOW	PAST	ENDOCRINE	NOW	PAST	MUSCULOSK	NOW	PAST
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Blurry	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerant	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Double	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerant	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
						Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms	<input type="checkbox"/>	<input type="checkbox"/>

EARS	NOW	PAST	NOSE	NOW	PAST	PSYCHOLOGIC	NOW	PAST	NEUROLOGIC	NOW	PAST
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Interest	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problem	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
THROAT	NOW	PAST	HEAD	NOW	PAST	Suicidal Ideas	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Speech	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
						Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Hand Tremors	<input type="checkbox"/>	<input type="checkbox"/>

SKIN	NOW	PAST	MOUTH	NOW	PAST	PAST MEDICAL HISTORY					
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Bladder Prob	<input type="checkbox"/>	Parasites	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Mole Changes	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Autoimmune	<input type="checkbox"/>
CHEST	NOW	PAST	BREASTS	NOW	PAST	Arthritis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>
Short Breath	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Sexual Prob	<input type="checkbox"/>	STD	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	Kidney Infect	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>						
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>									

HEART	NOW	PAST	GASTROINT	NOW	PAST	WOMAN	NOW	PAST	MAN	NOW	PAST
Cold Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Sex	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Edema	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Libido	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Irreg Periods	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Varicosity	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD/LYMPH		
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Libido	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Spotting	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURIN	NOW	PAST	Black Stool	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Flow	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Urine Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	UTI	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Incontinance	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>						
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>						
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>						
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>						

Signature



APEX CHIROPRACTIC PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying Apex Chiropractic in writing except to the extent Apex Chiropractic has taken action and reliance on your consent. Please refer to the Notice of Privacy Policy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that Apex Chiropractic may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Apex Chiropractic to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Apex Chiropractic is not required to agree to requested restrictions. If Apex Chiropractic agrees to the requested restriction, Apex Chiropractic will honor the request and it will be binding on the office.

I hereby consent to the use and disclosure by Apex Chiropractic, its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations

I _____ (print name) do here by give Apex Chiropractic permission for
1: _____ 2: _____ 3: _____

to receive patient medical records and accounting information on my behalf.

Dates effective: ____/____/____ to ____/____/____

Patient Name: _____

Patient Signature: _____ Date: _____

Apex Employee: _____ Date: _____



MedPay (AUTO) INSURANCE VERIFICATION FORM

Auto Insurance: _____ Phone: _____ Fax: _____

Adjuster: _____ Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantors name: _____ DOB: ____/____/____

Address: _____ Phone: _____

Claim Number: _____

ASSIGNMENT OF BENEFITS:

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Apex Chiropractic.

RELEASE OF INFORMATION:

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT:

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Patient Signature: _____ Date: _____

Apex Chiropractic: _____ Date: _____

Colorado State Law requires Auto Insurance companies to provide you with \$5,000 to \$25,000 in MedPay per person in the vehicle following an auto accident. Please keep us updated if you are using MedPay for any other care or services.

MedPay: \$ _____

Used: \$ _____



Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality Chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your inborn given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions please feel free to ask us.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc, and although rare, minor fractures have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures, provided at Apex Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name: _____ Today's date: _____

Sign your name: _____