Patient Information

IF THIS IS DUE TO AN ACCIDENT PLEASE GIVE A COPY OF CAR INSURANCE CARD TO FRONT DESK AS WELL AS ATTORNEY INFORMATION AND ACCIDENT REPORT.

Today's Date _____ Name _____

How did you hear about us? _____ Do you know someone who is currently coming to our office _____

S.S. # _____ D.O.B. _____ Height_____ Weight_____lbs Email address _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell #_____Wireless Carrier_____ Work #_____

Would you like to be reminded of appointments via email or text messaging the morning of? Y N (Circle one) TEXT EMAIL

Occupation _____ Employer _____Contact_____

Employer Address _____ City _____ State _____ Zip _____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Company _____ ID# _____ Group#_____ Insured_____

Race/Ethnicity: □ White/Caucasian □ Black/African American □ Asian □ American Indian □ Native Hawaiian □ Hispanic/Latino/Spanish Origin

Language: □ English □ Spanish □ Chinese □ Other: _____

List all hobbies/interest that you have_____

What were you able to do before that you would like to be able to do again _____

What is your expectation for your visit today?_____

INFORMED CONSENT

I hereby consent to the performance of chiropractic adjustment and other procedures deemed necessary by the practicing doctor of chiropractic. I understand that results are not guaranteed and that there are slight risks to treatment, including but not limited to muscle strains and sprains, disc injuries, and strokes, or other possible complications unforeseen. I intend this consent to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment. I hereby give my consent to allow Plus Care Chiropractic clinic and its representatives to take x-rays as deemed appropriate.

Signed _____ Date _____

Parent/Guardian _____ Date _____

FEMALES ONLY: I declare that to my knowledge, I am NOT pregnant. Initial_____

PAYMENT POLICY

1) Unless prior arrangement is made, full payment is due at the time of service. Your payment options are: cash, check, or credit/debit cards. We accept Visa, Master Card, Discover, or American Express, Care Credit.

2) Insurance Billing

.. If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the non-guaranteed information they provide to us.

.. You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).

.. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.

.. If you decide to suspend or terminate care you are still responsible for services rendered payment is due immediately.

.. Insurance companies may reimburse differently than the information they initially provide to us; you are responsible for and will be billed for any resulting unpaid balance.

3) Students, currently enrolled in accredited academic programs, will receive a 30% discount on all services and 20% discount on all products if they pay in full at the time of service.

4) Missed Appointments/Late Cancellations - All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, you will be charged $20 for the missed appointment.

5) Past Due Accounts- Accounts greater than 30 days past due will be charge a $10 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency. These policies are subject to change without notice.

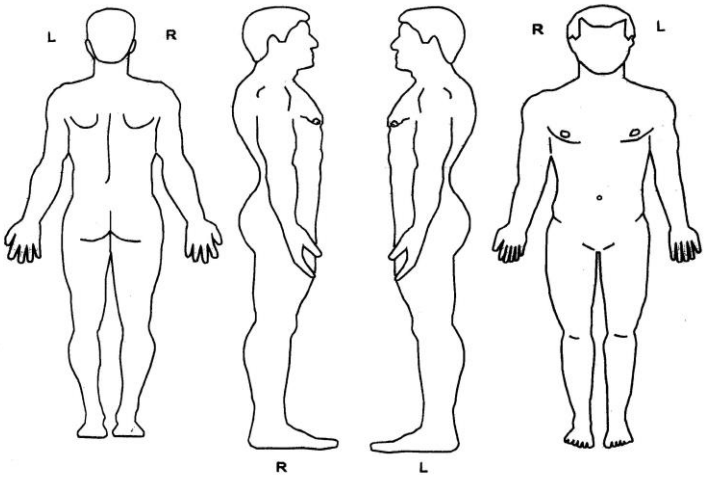
I have read, understood and agree to the policies described above:

Print Name: _____ Sign: _____ Date: _____

Name _____ Date _____
What is your main complaint today? _____
Briefly describe your symptoms_____
How long have you had this condition? _____
How did this condition begin? _____
Is this condition due to (circle one) trauma repetitive activity work related post surgical auto accident unspecified
If you've had surgery when was it and what area did you have surgery performed_____
Is there anything that will make this condition better? _____
Is there anything that will make this condition worse?_____
Is there any part of the day that your condition is better? _____
Is there any part of the day that your condition is worse? _____
Has your condition been constant or does it come and go?_____
What has the average pain intensity been in the last 24 hrs (circle one) no pain 1 2 3 4 5 6 7 8 9 10 worst pain
What has the average pain intensity been in the last week (circle one) no pain 1 2 3 4 5 6 7 8 9 10 worst pain
How often do you experience your symptoms (circle one) Constantly 76%-100% Frequently 51-75% Occasionally 26-50% Intermittently 0-25%
How much have your symptoms interfered with your usual daily activities Not at all A little bit Moderately Quite a bit Extremely
How has your condition changed since coming into our office NA first visit Worse A little worse None A little better Better Much Better
What would you say your health is overall right now Excellent Very Good Good Fair Poor
Is your condition interfering with: □ work □ sleep □ daily routine □ other _____
Have you ever been in any type of auto accident? _____ When? _____ Describe_____
Have you ever had any mental or emotional disorders? _____ Explain _____
Do you smoke? Y N How much_____/day Drink sodas? Y N How many? _____/day Alcohol? Y N How much _____/day
Have you seen any other health care practitioner for this condition? If so, who and when?_____
What medications are you currently taking :_____

Are you interested in having a nutritional consultation today at no additional cost? Y N
Please describe what your primary complaint is nutritionally_____

Is this pain: □ Sharp □ Stabbing □ Dull □ Achy □ Throbbing □ Tingling □ Stiff □ Burning □ Numb
Please indicate the area of complaint on the drawing.



Do you have any of the following contraindications to therapy or an ionic foot bath:
□ Pacemaker □ Other implanted electronic devices (list) _____
□ Organ Transplants
□ Heart Medications
□ Blood Thinners
□ Pregnant

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name _____ Date _____

Neck Index

Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
□ I have no pain at the moment.
□ The pain is very mild at the moment.
□ The pain comes and goes and is moderate.
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment.
□ The pain is the worst imaginable at the moment.

Sleeping
□ I have no trouble sleeping.
□ My sleep is slightly disturbed (less than 1 hour sleepless).
□ My sleep is mildly disturbed (1-2 hours sleepless)
□ My sleep is moderately disturbed (2-3 hours sleepless).
□ My sleep is greatly disturbed (3-5 hours sleepless).
□ My sleep is completely disturbed (5-7 hours sleepless).

Reading
□ I can read as much as I want with no neck pain.
□ I can read as much as I want with slight neck pain.
□ I can read as much as I want with moderate neck pain.
□ I cannot read as much as I want because of moderate neck pain.
□ I can hardly read at all because of severe neck pain.
□ I cannot read at all because of neck pain.

Concentration
□ I can concentrate fully when I want with no difficulty.
□ I can concentrate fully when I want with slight difficulty.
□ I have a fair degree of difficulty when I want.
□ I have a lot of difficulty concentrating when I want.
□ I have a great deal of difficulty concentrating when I want.
□ I cannot concentrate at all.

Lifting
□ I can lift heavy weights with out extra pain.
□ I can lift heavy weights but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
□ I can only lift very light weights.
□ I cannot lift or carry anything at all.

Personal Care
□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself & I'm slow and careful.
□ I need some help but I manage most of my personal care.
□ I need help every day in most aspects of self care.
□ I do not get dressed, I wash with difficulty and stay in bed.

Headaches
□ I have no headaches at all.
□ I have slight headaches which come infrequently.
□ I have moderate headaches which come infrequently.
□ I have moderate headaches which come frequently.
□ I have severe headaches which come frequently.
□ I have headaches almost all the time.

Driving
□ I can drive my car without any neck pain.
□ I can drive my car as long as I want with slight neck pain.
□ I can drive my car as long as I want with moderate neck pain.
□ I can drive my car as long as I want b/c of moderate neck pain.
□ I can hardly drive at all because of severe neck pain.
□ I cannot drive my car at all because of neck pain.

Recreation
□ I can engage in all my recreation activities without pain.
□ I can engage in all my usual activities with some neck pain.
□ I can engage in most but not all my usual activities b/c of neck pain.
□ I can only engage in a few of my activities b/c of neck pain.
□ I can hardly do any recreation activities b/c of neck pain.
□ I cannot do any recreation activities at all.

Work
□ I can do as much work as I want.
□ I can only do my usual work but no more.
□ I can only do most of my usual work but no more.
□ I cannot do my usual work.
□ I can hardly do any work at all.
□ I cannot do any work at all.

Please indicate on the scale your level of **pain in your neck.**

No Pain I----------I Extreme Pain

Back Index

Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
□ The pain comes and goes and is very mild.
□ The pain very mild and does not vary much.
□ The pain comes and goes and is moderate.
□ The pain is moderate and does not vary much.
□ The pain comes and goes and is very severe.
□ The pain is very severe and does not vary much.

Changing Degree of Pain
□ My pain is rapidly getting better.
□ My pain fluctuates but overall is definitely getting better.
□ My pain seems to be getting better but improvement is slow.
□ My pain is neither getting better or worse.
□ My pain gradually worsening.
□ My pain is rapidly worsening.

Sleeping
□ I don't get pain in bed.
□ I get pain in bed but it does not prevent me from sleeping well.
□ Because of pain my normal sleep is reduced by less than 25%.
□ Because of pain my normal sleep is reduced by less than 50%.
□ Because of pain my normal sleep is reduced by less than 75%.
□ Pain prevents me from sleeping at all.

Sitting
□ I can sit in a chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me from sitting more than 1 hour.
□ Pain prevents me from sitting more than 30min.
□ Pain prevents me from sitting more than 10 min.
□ I avoid sitting because it increases pain immediately.

Personal Care
□ I don't have to change my way of washing or dressing to avoid pain.
□ I don't change washing or dressing even though it causes pain.
□ Washing and dressing increases pain but I don't change ways.
□ Washing and dressing increases pain and I change my ways.
□ I'm unable to do some washing or dressing alone b/c of pain.
□ I'm unable to do any washing or dressing alone b/c of pain.

Walking
□ I have no pain while walking.
□ I have some pain walking but it doesn't increase w/ distance.
□ I cannot walk more than 1 mile without increasing pain.
□ I cannot walk more than ½ mile without increasing pain.
□ I cannot walk more than ¼ mile without increasing pain.
□ I cannot walk at all without increasing pain.

Traveling
□ I have no pain while traveling.
□ I get some pain traveling, but it doesn't make pain worse.
□ I get extra pain traveling, but don't seek alternate forms of travel.
□ I get extra pain traveling which makes me seek alternate travel plans.
□ Pain restricts all forms of travel except that done while lying down.
□ Pain restricts all forms of travel.

Standing
□ I can stand as long as I want without pain.
□ I have some pain standing but it does not increase with time.
□ I cannot stand for long than 1 hour without increasing pain.
□ I cannot stand for longer than ½ hour without increasing pain.
□ I cannot stand for longer than 10 min. without increasing pain.
□ I avoid standing because it increases pain immediately.

Lifting
□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor.
□ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on table).
□ Pain prevents me from lifting heavy weights off the floor, but I manage light to medium weights if they are conveniently positioned (e.g. on table).
□ I can only lift very light weights.

Social Life
□ My social life is normal and gives me no extra pain.
□ My social life is normal but increases the degree of pain.
□ Pain has no affect on social life except energetic interests.
□ Pain has restricted my social life and I don't go out very often.
□ Pain has restricted my social life to my home.
□ I have hardly any social life because of pain.

Please indicate on the scale your level of **pain in your back.**

No Pain I----------I Extreme Pain

THIS IS A CONFIDENTIAL HEALTH REPORT

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

GENERAL
- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness or fainting
- ☐ Headache
- ☐ Neuralgia
- ☐ Numbness

MUSCLE
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Low back pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints

PAIN, NUMBNESS, OR CRAMPS
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

SKIN
- ☐ Bruise easily
- ☐ Dryness
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

GASTRO-INTESTINAL
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digesting
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Pain in stomach

EYES, EARS, NOSE, & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Eye pain
- ☐ Nasal obstruction
- ☐ Sinus infection

CARDIO-VASCULAR
- ☐ Hardening of the arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain in heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

FOR WOMEN ONLY
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular Cycle
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Pregnant

Check the following conditions you have or had. Circle items that are common to other family members.

☐ Aids	☐ Chicken Pox	☐ Goiter	☐ Pneumonia	☐ Stroke
☐ Alcoholism	☐ Diabetes	☐ Gout	☐ Polio	☐ Tuberculosis
☐ Anemia	☐ Eczema	☐ Heart Disease	☐ Multiple Sclerosis	☐ Typhoid Fever
☐ Appendicitis	☐ Emphysema	☐ Malaria	☐ Mumps	☐ Ulcers
☐ Arteriosclerosis	☐ Epilepsy	☐ Measles	☐ Rheumatic Fever	☐ Venereal Disease
☐ Cancer	☐ Foot Problems	☐ Pacemaker	☐ Scarlet Fever	

Please list any **prescription drugs** now taken, **allergies**, and **past surgeries**

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name _____ Date _____

PLUS CARE CHIROPRACTIC & WELLNESS • 1809 E. 10th Street • Jeffersonville, IN • 47130
Phone: (812) 282.8977 • Fax: (812) 280.5253

NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

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.

Plus Care Chiropractic 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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare options. (Example)
"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Plus Care Chiropractic."
"It is our policy to provide a substitute health care provider, authorized by Plus Care Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's 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 Plus Care Chiropractic 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 disclose 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 a family member, or another person responsible for your care about your medical condition or in the event or an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling 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 reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

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

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent 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 purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (Example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we leave a reminder message on your answering machine or with the 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."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Plus Care Chiropractic sponsored fund-raising events."

Change Ownership

In the even that Plus Care Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

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 Plus Care Chiropractic is not required to agree to the restrictions that you 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 Plus Care Chiropractic amend your protected health information. Please advise, however, that Plus Care Chiropractic is not required to amend your 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 a right to receive an accounting of disclosures of your protected health information made by Plus Care Chiropractic.

- 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

Plus Care Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains until such amendment is made, Plus Care Chiropractic is required by law to comply with this notice.

Plus Care Chiropractic 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 if you want more information about your privacy rights, please contact April Simmons by calling this office at 812-282-8977. If April Simmons is not available, you may make an appointment for a personal conference in person or by telephone within 2 days.

Complaints

Complaints about your privacy rights, or how Plus Care Chiropractic has handled your health information should be directed to April Simmons by calling this office at 812-282-8977. If April Simmons is not available, you may make an appointment for a personal conference in person or by telephone within 2 days.

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 Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

I have read the Privacy Notice, received a copy and understand my rights of this notice. By way of my signature, I provide Plus Care Chiropractic 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.

************THIS PRIVACY NOTICE IS YOURS TO KEEP FOR YOUR RECORDS************

Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Plus Care Chiropractic's "NOTICE OF PRIVACY PRACTICES," revision date April 14, 2003.

I, _____, have been informed a copy of PLUS CARE CHIROPRACTIC & WELLNESS, Notice of Privacy Practices, is posted in the waiting room area. A copy of this Notice will be furnished to me upon my request.
Patient Signature_____ Date_____/_____/_____

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding: unique identifiers for health plans, providers, individuals, employers, healthcare transaction & code sets for transmitting data electronically, privacy regulations over disclosure and use of health information. Security regulations over protections of electronic health information.

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following
I authorize PLUS CARE CHIROPRACTIC & WELLNESS to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone □ YES □ NOVoice Mail □ YES □ NO Answering Machine □ YES □ NO Work Telephone □ YES □ NO
Cell Phone/Voice Mail □ YES □ NO Cell Phone/Text □ YES □ NO Email □ YES □ NO

May we fax medical records for referrals? □ YES □ NO
Please list names of people with whom we may discuss your medical care:
Spouse Name _____ □ YES □ NO
Parent Name _____ □ YES □ NO
Other Name _____
Relationship _____ Phone (_____) _____ - _____

MEDICAL RECORDS/IMAGING: I authorize the release of any and all information/records/x-rays, etc. need to evaluate my condition. I further request that this and any other pertinent information be forwarded to PLUS CARE CHIROPRACTIC & WELLNESS, 1809 E 10th St, Jeffersonville, IN 47130, Fax: 812-280-5253.

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including physical therapy treatments, massage therapy and manipulations. I grant my consent for treatment for myself, my spouse, or my minor children/dependent as listed on this form.

RELEASE OF CREDIT INFORMATION: When applying for a Care Credit card, I hereby authorize PLUS CARE CHIROPRACTIC & WELLNESS and/or its assign all rights necessary to obtain financial information on me or my spouse in order to make determination of my credit worthiness. Additionally, I authorize PLUS CARE CHIROPRACTIC & WELLNESS and or its assigns to obtain a pre-approval for credit on services or treatments that may or may not be utilized in our office

As required by the Privacy Regulations, I am aware that Plus Care Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information
- I wish to file a "Request for Alternative Communications" of my Protected Health Information
- I wish to object to the following in the "Notice of Privacy Practices:" _____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature _____ Date _____

Print Name _____

(OFFICE USE ONLY)

Signed form received by staff member _____ Date _____

Plus Care Chiropractic & Wellness Center

May 20, 2015

RE: Massage Policy

To Whom It May Concern:

Cancellations have become a problem and it is getting difficult to maintain our schedules and provide the needed services to our patients. Therefore, it is necessary to institute and enforce a new policy.

1. If you cancel a massage appointment without a **48 hour** notice, a one-time grace will be given.
2. The second and third cancellation without a **48 hour** notice will result in a $10 charge for 30 minute massages and $20 charge for 60 minute massages.
3. A fourth cancellation will result in massages being reduced to 15 minutes, unless someone else has cancelled.

By my signature, I acknowledge that I have read, understand, and agree to the policy stated above.

_____ _____

Patient Signature Date

_____

Print Name