KENNETH B. FREDERICK, D.C.
KAREN BUSSO, D.C.

FREDERICK CHIROPRACTIC
2501 Mile Hill Dr. A-101
Port Orchard, WA 98366
Phone: 360-895-4843/ Fax: 360-895-4210

CASE HISTORY

Date: _____

Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell _____ Work Phone: _____
Age: _____ Birth Date: _____ Marital Status: S M W D | EMAIL: _____
Occupation: _____ Employer: _____ City: _____
Name of Spouse: _____ Birth Date of Spouse: _____
Spouses SS # (for insurance) _____ Spouses Occupation: _____
Emergency Contact (*If different from Spouse*): _____
Phone: _____ **Relationship:** _____

How were you referred to our office? _____
Have you ever seen a chiropractor before? _____ If yes, Who/When? _____

Primary Complaint _____
How long have you had this complaint? _____

Is this the result of an injury/accident, if yes, please explain? _____
_____

Are the pains (please circle): SHARP DULL ACHE CONSTANT INTERMITTENT

Has it interfered with daily activities, such as (please circle): WORK HOME SLEEP SELF CARE SPORTS OR OTHER (please list): _____
What makes it worse? _____
What makes it better? _____
Is it worse during certain times of the day? _____ If yes, when? _____
Have you had this before? _____ If yes, when? _____
Is this condition getting progressively worse? YES / NO

List other doctors consulted for these complaints/injuries:

1. Name: _____ When consulted: _____
   Treatment _____ Results: _____

2. Name _____ When consulted: _____
   Treatment _____ Results: _____

Any home remedies, ice, heat, etc.: _____
Other complaints: _____
_____

I give my permission for the doctors at Frederick Chiropractic to treat my minor child:

Parent/Guardian Signature: _____ **Date:** _____

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PAST HEALTH HISTORY

Name:_____ Date:_____

Please indicate for each of the questions below your experience by use of the following codes:

1- Never 2-Previously Had 3-Presently Have

Musculoskeletal System
__Low back problems
__Pain between shoulders
__Neck problems
__Head pain
__Arm problems
__Leg problems
__Swollen joints
__Painful joints
__Weak muscles
__Walking problems
__Disc problems
__Poor posture
__Pain-shoulder/arm/hand
__Rib cage pain
__Painful tailbone
__Buttock pain
__Hip pain
__Leg pain-lower/upper

General
__Fatigue
__Allergies
__Loss of sleep
__Fever
__Headaches

Gastrointestinal
__Poor appetite
__Excessive hunger
__Excessive thirst
__Vomiting blood
__Liver trouble
__Gall Bladder
__Weight trouble
__Bloating after meals
__Heartburn
__Black/bloody stool

Cardiovascular/ Respiratory System
__Chest pain
__Pain over heart
__Difficulty breathing
__Persistent cough
__Coughing blood
__Rapid heart rate
__Blood pressure problems
__Heart problems
__Lung problems
__Varicose veins
__Ankle swelling
__Stroke

Eye, Ear, Nose & Throat
__Vision problems
__Ear noises
__Difficult speech
__Facial/jaw pain

Genitourinary System
__Bladder trouble
__Painful urination
__Discolored urine
__Bed wetting

Male/Female
__Prostate
__HIV positive
__Breast pain
__Breast-lumps/congested
__Periods-painful/excess
__Periods-irregular/cramp
__Hot flashes
__Menopause

Female Only
Date of last period?
_____

Are you pregnant?
__Yes __No __Not sure

Nervous System
__Nervousness
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/Depression
__Fainting
__Convulsions
__Cold/tingling extremities
__Stress
__Tremors

Childhood injuries/traumas:

_____
_____
_____

Dr's Notes:
_____
_____

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Health History *(Continued)*:

Patient Name: _____ **Date:** _____

List of Surgical Operations & Years:	**Medications:**
_____	_____
_____	_____
_____	_____
Age Of Mattress: _____	**Are You Wearing:**
Comfortable: Yes / No **Uncomfortable:** Yes / No	**Heel Lifts:** Yes / No **Sole Lifts:** Yes / No
Sleeping Posture: Side / Stomach / Back	**Inner Soles:** Yes / No **Arch Supports:** Yes / No
Have you been in an auto accident? **Date(s) Of Injury:**	**List any hobby / sports injuries:**
In the past year? Yes / No _____	_____
In the past 5 years? Yes / No _____	_____
Over 5 years ago? Yes / No _____	_____
Describe: _____	_____
Have you ever had any mental or emotional disorders?	**Have others in your family had such disorders?**
Yes / No When? _____	Yes / No When? _____
Describe: _____	Describe: _____

Have You Ever?	**Yes / No**	**Describe:**
Been knocked unconscious?	Yes / No	
Been treated for a spine or nerve disorder?	Yes / No	
Had a fractured bone?	Yes / No	
Been hospitalized other than surgery?	Yes / No	
Do You?	**Yes / No**	**Describe:**
Now take vitamins or minerals?	Yes / No	
Think you may need vitamins or minerals?	Yes / No	

Date Of Last:	**0-6 Months**	**6-18 Months**	**Over 18 Months**	**Never**	**List all conditions for which you have been treated in the last 10 years:**
Spinal Exam					
Physical Exam					
Chest X-Ray					
Spinal X-Ray					
Urine Test					
Habits:	**Heavy**	**Moderate**	**Light**	**None**	
Alcohol					
Coffee/Tea					
Tobacco					
Exercise					
Sleep					
Appetite					
Physical Stress					
Mental Stress					

Family Health Information: (Many health problems are the result of hereditary spinal weaknesses; thus, information about your family members will give us a better picture of your total health. Please include conditions such as heart disease, arthritis, cancer, diabetes, etc.)

Name	**Relation**	**Past & Present Health Problems**

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AUTHORIZATION FOR ASSIGNMENT OF PAYMENT

I hereby authorize and assign payment directly to:

Frederick Chiropractic
2501 Mill Hill Rd Ste A-101
Port Orchard, WA 98366

For professional services rendered I shall be personally responsible for any unpaid balance to the doctor. I hereby authorize the attending doctor to release any information concerning my examination and or treatment.

This form is used in lieu of the patient's signatures on the HCFA 1500 form and is, therefore an extension of that form.

Date: _____

Signature: _____
(OR Parent / Guardian of minor child)

First Insured name: _____

First Insured Social Security # _____

Insured date of birth: _____

Insured Employer: _____

Employer Location (City): _____

Employer Work Phone: _____

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FINANCIAL AGREEMENT

Payment for all services/supplies, provided to you or your dependents, are due at time of service unless other written arrangements have been made.

As a courtesy, we will submit your insurance claims directly to your insurance company(ies). However, you are ultimately solely responsible for payment of all of your account charges regardless of whether you expect your insurance company to make reimbursements for covered healthcare expenses.

By signing this agreement, you hereby do agree to remit any insurance payment sent to you for unpaid portions of your charges to the office within 10 days of receipt of reimbursement to be applied to any unpaid balances on your account.

Unpaid charges for services greater than 30 days past due will be charged and additional 6.0% monthly interest until those charges are paid in full.

If a check is returned to our office as "NSF" (non-sufficient funds) your account will automatically be charged a $35 fee which you will be held responsible for and agree to pay in full upon notification.

A photocopy of this agreement shall be considered as effective and valid as the original.

Patients Name: _____ **Date**: _____

Signature: _____
(OR Parent / Guardian of minor child)

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INSURANCE PATIENTS FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have chiropractic insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. You are considered a cash patient until you present your insurance card and this office qualifies and accepts your coverage.

2. All payments are expected at the time of service. Patients' balances may not exceed $150 at any time.

3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service.

4. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 6.0% per month. Charges may also be made for missed appointments and those cancelled without 24-hour notice.

5. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full or any outstanding balance and the courtesy of insurance assignment is immediately discontinued.

6. If a check is returned to our office as "NSF" (non-sufficient funds) your account will automatically be charged a $35 fee which you will be held responsible for and agree to pay in full upon notification.

We must emphasize that as chiropractic providers, our relationship is with you personally, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. This insurance assignment policy must be followed and we ask that your sign this form as acknowledgment that our policy was explained to you, that you understand it and accept full responsibility.

Date: _____

Patient's Name: _____

Patient's Signature: _____
(OR Parent / Guardian of minor child)

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Name: _____ Date: _____

Signature: _____
(OR Parent / Guardian of minor child)

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Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

A) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

B) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

C) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidences has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the consent of this consent

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Date: _____

Patient Name_____

Signature: _____
(OR Parent / Guardian of minor child)

Rev: 2019

Medical Appointment Cancellation Policy

Dear patient,

Thank you for trusting your chiropractic care to Frederick Chiropractic/Busso Chiropractic. We strive to render excellent chiropractic care to you and your family. In order to be consistent with this philosophy, Frederick/Busso Chiropractic uses an appointment system that sets aside ample 1:1 patient care time for treatment with your provider.

If you do not show up for an appointment, or notify us of your inability to keep your appointment by phone at least 12 hours in advance, the time allotted for your visit cannot be used to treat another patient. With that in mind, a Medical Appointment Cancellation Policy has been put into place.

Our Policy is as follows:

1. We require that you give our office at least 12 hour notice in the event that you need to cancel or reschedule your appointment. This will make the appointment time available to someone else. Our number is (360) 895-4843.
2. If you miss an appointment and do not contact us with at least 12 hours prior notice, we will consider this to be a "late cancellation/no show" appointment and a $35 fee will be assessed to you. Insurance does not pay for "late cancellation/no show" appointments.
3. If you have 3 "late cancellation/no show" appointments, you may be removed from the schedule and be seen on a same day call in basis depending on availability.
4. If you are more than 5 minutes late to your appointment, your appointment may be shortened or rescheduled.
5. As a courtesy we send out text and email reminders through our automated system. In the event there are technical difficulties the cancellation policy will still stay in effect.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

_____ _____

Signature (Parent/ Legal Guardian Relationship to patient

_____ _____

Printed Name Date

Copy of signed form given to patient _____ _____

Staff Initial Date

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OFFICE POLICY

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

Multiple appointments can be scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. This office reserves the right to charge for missed appointments and those cancelled without 24-hour notice**. It is your obligation to make up a missed appointment within 7 days of cancellation.**

Our office hours are as follows:
Monday, thru, Friday 9:00 - 12:00 & 2:00 - 6:00
Saturday 9:00 - 11:00

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. You may have to wait for the next available appointment if you are late or early. We try very hard to stay on our schedule so patients may get on with their day.

All co-payments are due at the time of service. Also, any payments going towards your insurance deductible is to be paid at the time of service until deductible obligation is met.

Hippa Notice of Privacy Practices

Your Protected Health Information will be used by ***Frederick Chiropractic*** and will only be disclosed to others for the purposes of treatment, obtaining payment, or for internal use regarding the day-to-day health care operations of this office.

I authorize my name, phone number and email address, to be attached to a patient message system for any notifications of my appointments or other communication via an automated outreach system.

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to our privacy practice, please ask to speak with our HIPPA Compliance Officer in person or by phone at our office.

Your signature below acknowledges that you are aware of the "Notice of Patient Privacy Policy" and that a copy of this policy is available in the lobby for you to review. You may also receive a copy of ***FREDERICK CHIROPRACTIC'S*** "Notice of Patient Privacy Policy" upon request.

Patient's Name (Print): _____ Date: _____

Patient or Parent's Signature: _____

(Revised 06/2019)

Frederick Chiropractic
2501 Mile Hill Dr. Ste A-101
Port Orchard, Washington 98366
PH: 360-895-4843

Notice of Patient Privacy Policy

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.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Dr. Kenneth Frederick

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website pochirohelp.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

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

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students.

  For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then

your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint, you may go to: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html*

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Dr. Kenneth Frederick. You may contact our Privacy Officer or any staff member, including Anita Frederick, at the following phone number: 360-895-4843 or on our website: pochirohelp.com for further information about the complaint process.

This notice was published and becomes effective on January 1, 2022

Patient signature_____ Patient has declined copy Yes___ No____