CASE HISTORY

Name:_____ Age:_____ Date:_____ Case Number:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone:(H)_____(C)_____Fax:_____ E-mail:_____
Date of Birth:_____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children:_____
Occupation:_____ Employer:_____ Telephone (Work):_____Ext.____
Insured's Name:_____ Phone:_____ Insured's Date of Birth:_____
Spouse's Name:_____ Spouse's Occupation:_____
Spouse's Employer:_____ Spouse's Telephone (Work):_____
Past Chiropractic Care: ❑ Yes ❑ No When?_____ Doctor's Name:_____
Results:_____ Referred by:_____
Insurance Company:_____ Telephone:_____
Social Security Number:_____ Driver's License Number:_____ State:_____
Spouse's Insurance Company:_____ Telephone:_____
Spouse's Social Security Number:_____ Spouse's Driver's License Number:_____
Emergency Contact:_____Relationship_____Contact Number_____

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other:___
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other:_____
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When?_____ Why?_____
Have you retained an attorney? ❑ No ❑ Yes Name & Address:_____

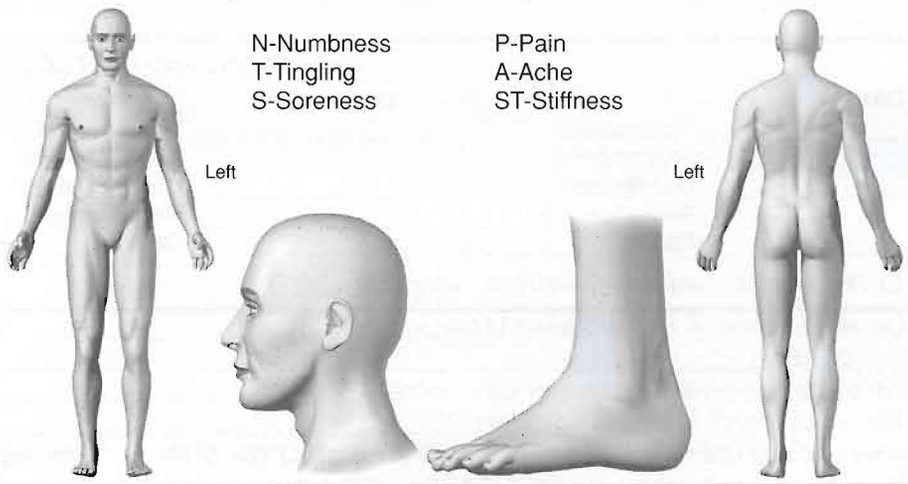
Pain Symptoms: (in order of severity)
1. _____ Began-(Mo/Yr):_____ Previous Episodes:_____
2. _____ Began-(Mo/Yr):_____ Previous Episodes:_____
3. _____ Began-(Mo/Yr):_____ Previous Episodes:_____

Please mark the intensity of your pain today.
0 - NO PAIN
10 - INTENSE PAIN
Example Neck
O 1 2 3 ④ 5 6 7 8 9 10
1. _____
O 1 2 3 4 5 6 7 8 9 10
2. _____
O 1 2 3 4 5 6 7 8 9 10
3. _____
O 1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



DOCTORS USE ONLY

_____
_____
_____
_____

HABITS

❑ Smoking Packs/Day:_____
❑ Drinking Alcohol:_____
❑ Caffeine Cups/Day:_____

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑ _____
Brother,# of:___	❑	❑	❑	❑	❑ _____
Sister,# of:___	❑	❑	❑	❑	❑ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS	
❑	❑	❑	995.3	Allergy (What)____
❑	❑	❑	490	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.39	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.79	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Sweats
❑	❑	❑	786.07	Wheezing
❑	❑	❑	311	Depression

Never	Previously	Presently	GASTRO-INTESTINAL	
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	788.36	Bed Wetting
❑	❑	❑	599.7	Blood in Urine
❑	❑	❑	788.4	Frequent Urination
❑	❑	❑	788.3	Lack of Bladder Control
❑	❑	❑	590.9	Kidney Infection
❑	❑	❑	788.1	Painful Urination
❑	❑	❑	601.9	Prostate Trouble

			MUSCLES/JOINTS/BONES	
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors/Twitching
❑	❑	❑	782	Arm Trouble

			CARDIO-VASCULAR	
❑	❑	❑	401.9	High Blood Pressure
❑	❑	❑	458.9	Low Blood Pressure
❑	❑	❑	786.51	Pain Over Heart
❑	❑	❑	785.9	Poor Circulation
❑	❑	❑	438	Previous Heart Trouble
❑	❑	❑	785.0	Rapid Heart
❑	❑	❑	427.89	Slow Heart
❑	❑	❑	436	Strokes
❑	❑	❑	719.7	Swelling Ankles
❑	❑	❑	454	Varicose Veins

			SKIN OR ALLERGIES	
❑	❑	❑	680.9	Boils
❑	❑	❑	924.9	Bruising Easily
❑	❑	❑	701.1	Dryness
❑	❑	❑	691.8	Eczema
❑	❑	❑	708.9	Hives or Allergy
❑	❑	❑	698.9	Itching
❑	❑	❑	782.0	Sensitive Skin
❑	❑	❑	782.1	Skin Eruptions

			FOR WOMEN ONLY	
❑	❑	❑	625.3	Cramps or Backaches
❑	❑	❑	626.2	Excessive Flow
❑	❑	❑	627.2	Hot Flashes
❑	❑	❑	626.4	Irregular Cycle
❑	❑	❑	634.9	Miscarriage
❑	❑	❑	625.3	Painful Periods
❑	❑	❑	623.5	Vaginal Discharge
❑	❑	❑	611.79	Lump in Breast
❑ Yes ❑ No				Pregnant at this time?
❑ Yes ❑ No				Have you had a mammogram?
_____				Last Pap Smear Date
_____				By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation: _____
❑ Sports:_____ ❑ School:_____ ❑ Other: _____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? ❑ Yes ❑ No Why? _____
Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No
Have you ever had a lapse of memory? ❑ Yes ❑ No
Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

Legacy Chiropractic & Sports Medicine

Informed Consent

Amy R. Lewis, D.C.
17754 Preston Rd. Suite 100
Dallas, TX 75252
Phone (469)343.4202

Healthcare providers, including Chiropractors, are required by law to inform you of the nature of your condition, the general nature of the treatment, the risk involved, and the reasonable therapeutic alternatives. In keeping with the Texas law of informed consent, you are being asked to sign a confirmation that we have discussed these matters. Please read this form carefully. Ask about anything you do not understand and we will be pleased to explain it.

In general, chiropractic treatment includes examination, manipulation/adjustment, and application of physical therapy modalities. Since chiropractic is a hands on therapy, incidental contact to regions of the body not being adjusted may occur (ex. Rib, Hip, Sacrum adjustments, etc.) Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

Stroke- a rare but serious problem associated with spinal manipulation. Results can be temporary or permanent dysfunction. This problem occurs so rarely that there is no conclusive data to quantify probability.

Disc herniation- Herniations can create pressure on the spinal nerve or cord and are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

Soft tissue injury- Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there were no long term effects for the patient.

Rib Fracture- Ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurrence is primarily in patients who have weakened bones from such things as osteoporosis. We adjust all patients carefully, especially those who have indications of osteoporosis.

---------- **Consent** ----------

I hereby authorize and direct Dr. Amy R. Lewis along with associates/assistants to provide chiropractic treatment including exam, diagnostics, spinal manipulation (adjustment), physical therapy or other procedures deemed necessary and reasonable. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. I also acknowledge that I have been given the opportunity to review the notice of privacy practices. This authorization for consent to chiropractic treatment is and shall remain valid until revoked.

Patient's Name (printed) _____

Signature of patient, parent or guardian _____

Relationship to patient_____ Date_____

Dr. Amy R. Lewis, D.C.
17754 Preston Road
Dallas, TX 75252
Phone: 469.343.4202
Fax: 253.540.4202

Cancellation Policy / No Show Policy

It is our desire to provide you with the best possible care and attention that we are able to offer. We understand that there are times when you must miss an appointment due to obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Legacy Chiropractic and Sports Medicine kindly asks that you give us **24 hours' notice** if you need to cancel/change your scheduled appointment time. If an appointment is not cancelled at least 24 hours in advance, you will be charged **$1/per minute of a missed/late scheduled massage appointment; $35 for scheduled appointments canceled with less than 24 hour notice; $65 full price for missed adjustment appointments**; this will not be covered by your insurance company. Missed appointments will automatically be charged to the credit card we have on file. We understand that delays may happen, however we must try to keep other patients, doctors and massage therapists on time. Thank you for your cooperation.

I understand that I am asked to provide 24 hours' notice if I need to cancel/reschedule my appointment, and that I may be charged the fee noted for the treatment scheduled, if I do not give sufficient notice. I also authorize Legacy Chiropractic and Sports Medicine to process fees on the credit card I have placed on file if I miss or am late for an appointment.

Print Name: _____

Signature: _____ Date: _____

Name as it appears on the card: _____

Billing Address: _____

Card Type: _____

Card Number: _____

Expiration Date: _____ CVV2: _____

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or for which medical treatment or medical services were rendered hereunder ("condition") to pay directly to, and exclusively in the name of Legacy Chiropractic & Sports Medicine such sums as may be owing to Legacy Chiropractic & Sports Medicine for charges incurred by me at the office of Legacy Chiropractic & Sports Medicine relating to my condition and pay directly to, and exclusively in the name of Legacy Chiropractic & Sports Medicine such sums as may be owing to Legacy Chiropractic & Sports Medicine for charges incurred by me, including charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Legacy Chiropractic & Sports Medicine, in accordance with the definitions, rights, and remedies of Texas law including specifically, but not limited to, Texas Business & Commerce code 9.102 and the comments there under, with respect to my charge, and outstanding medical balance. This lien shall apply to all payers and to the full extent of Texas law. For the purposes of this Agreement/medical assignment and medical lien, benefits shall all include, but shall not be limited to, proceeds from any settlement, judgment or verdict, as well as any proceeds or recovery relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist cover, third-party liability distribution, malpractice proceeds, attorney retainer agreements, and any other benefits of proceeds coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits of proceeds payable to me for the purpose stated herein.

In addition I hereby assign to the office, insofar as permitted by law, the following: all my rights, remedies, and benefits to Legacy Chiropractic & Sports Medicine, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office's name, and the right to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter I hereby direct each attorney to issue a letter of protection to this office regarding to my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct (and the office hereby requests) each attorney to provide immediate notice to the office regarding any funds received by the attorney relation to my accident, to promptly pay the office out of such fund, and to provide full accounting of such funds to the office upon its request.

I hereby direct all payers to release Legacy Chiropractic & Sports Medicine any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to pay all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I understand that I remain personally responsible for the total amounts due to Legacy Chiropractic & Sports Medicine for its services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Legacy Chiropractic & Sports Medicine for all cost of such collection efforts, including, but not limited to, all court cost and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of Legacy Chiropractic & Sports Medicine and myself. I hereby revoke many previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the right and interest of Legacy Chiropractic & Sports Medicine and myself. However, should any provision of this agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding any party hereto, all other portions and provisions of this agreement shall, never the less, remain in full force and effect.

Print name (please print):_____.

Patient signature:_____.Date:_____.

Name of parent or legal guardian (please print):_____.

Parent/Guardian signature:_____.Date:_____.

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

Patient Name: _____ Date of birth: _____

The information you may release subject to this signed form is as follows:

- ☐ Complete records
- ☐ Lab reports
- ☐ Operative reports
- ☐ History & physical
- ☐ Hospital reports
- ☐ Progress notes
- ☐ Pathology reports
- ☐ Medication record
- ☐ Care plan
- ☐ Treatment records
- ☐ Other (please specify below)

_____

_____

Release my protected health information to the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The purpose/reason for this release of information is as follows:

_____

_____

I understand that Legacy Chiropractic and Sports Medicine will provide the information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Chiropractic Examiners.

I acknowledge that I have received, read and understood this office's Notice of Privacy Practices (HIPAA rules and regulations).

_____ _____

Patient Name | Signature of Patient or Personal Representative

_____ _____

Patient Date of birth or Social Security Number | Printed name of Patient or Personal Representative

_____ _____

Date | Description of personal representative's authority

Your Information. Your Rights. Our Responsibilities.
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.**
LAYERED SUMMARY TEXT –
Your Rights
You have the right to:
• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated
Your Choices
You have some choices in the way that we use and share information as we:
• Tell family and friends about your condition
• Provide disaster relief
• Include you in a hospital directory
• Provide mental health care
• Market our services and sell your information
• Raise funds
Our Uses and Disclosures
We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests
• Work with a medical examiner or funeral director
Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights by contacting us using the information on page 1.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
• We will not retaliate against you for filing a complaint.
Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes
In the case of fundraising:
• We may contact you for fundraising efforts, but you can tell us not to contact you again.
Our Uses and Disclosures
How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."