NORTHWEST WELLNESS CENTER

NEW PATIENT INFORMATION

WHOM MAY WE THANK FOR REFFERING YOU TO OUR OFFICE: _____ **TODAY'S DATE:** _____

PATIENT DEMOGRAPHICS:

Name: _____
Birth Date: _____-_____-_____ Age: _____ ❑ M ❑ F
Address: _____
City: _____State: _____ Zip: _____
Social Security:_____
Email: _____
Mobile #: _____
Occupation: _____

Marital Status:❑Single ❑Married ❑Widowed ❑Divorced ❑Engaged
Name of Spouse: _____
Occupation: _____
Mobile#: _____
How many children do you have :_____
Emergency Contact:_____
Relationship: _____Phone#:_____

INSURANCE INFORMATION:

Do you have Medicare? ❑ Yes ❑ No If yes, do you have secondary insurance? ❑ Yes ❑ No

HISTORY OF COMPLAINT:

1. Please identify the condition(s) that brought you to our office:
   1st: _____ 2nd: _____ 3rd: _____

2. On a scale of 0-10 (0 = no pain and 10 = worst pain), rate your above complaints, by checking the number **THAT APPLIES**:
   1st : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   2nd: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   3rd : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

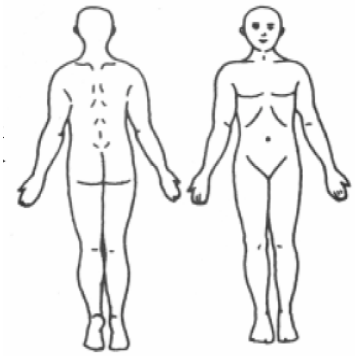
3. When did the complaint(s) begin? _____ When is the complaint(s) the worst? ❑ AM ❑ Mid-Day ❑ PM

4. How did the "injury" (complaint) happen? _____

5. How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

DESCRIBE YOUR SYMPTOMS:

PLEASE MARK the areas on the diagram with the following LETTERS:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness
S = Sharp/Stabbing **T** = Tingling ⟶



PAST HISTORY:

1. Have you suffered with this or a similar problem in the past? ❑ No ❑ Yes – If yes, How many times? _____
   When was the last episode? _____ How did the injury happen? _____

2. Other forms of treatment tried? ❑ No ❑ Yes – If yes, please state what type of treatment: _____
   and who provided treatment: _____ How long ago? _____
   What were the results? ❑ Favorable ❑ Unfavorable – Please explain: _____

3. Have you ever seen a chiropractor? ❑ No ❑ Yes – If yes, what were the results? ❑ Bad ❑ Good ❑ Great

ACTIVITIES OF DAILY LIVING:

1. No effect 3. Painful (activities limited)
2. Painful (can do) 4. Unable to perform

Bending	☐ 1	☐ 2	☐ 3	☐ 4
Carrying	☐ 1	☐ 2	☐ 3	☐ 4
Climbing	☐ 1	☐ 2	☐ 3	☐ 4
Computer work	☐ 1	☐ 2	☐ 3	☐ 4
Concentrating	☐ 1	☐ 2	☐ 3	☐ 4
Dancing	☐ 1	☐ 2	☐ 3	☐ 4
Doing Chores	☐ 1	☐ 2	☐ 3	☐ 4
Dressing	☐ 1	☐ 2	☐ 3	☐ 4
Driving	☐ 1	☐ 2	☐ 3	☐ 4
Gardening	☐ 1	☐ 2	☐ 3	☐ 4
Lifting	☐ 1	☐ 2	☐ 3	☐ 4
Playing Sports	☐ 1	☐ 2	☐ 3	☐ 4
Pushing	☐ 1	☐ 2	☐ 3	☐ 4
Reading	☐ 1	☐ 2	☐ 3	☐ 4
Recreational Activities	☐ 1	☐ 2	☐ 3	☐ 4
Rolling Over	☐ 1	☐ 2	☐ 3	☐ 4
Running	☐ 1	☐ 2	☐ 3	☐ 4
Sexual Activity	☐ 1	☐ 2	☐ 3	☐ 4
Shoveling	☐ 1	☐ 2	☐ 3	☐ 4
Sitting	☐ 1	☐ 2	☐ 3	☐ 4
Sitting to Standing	☐ 1	☐ 2	☐ 3	☐ 4
Sleeping	☐ 1	☐ 2	☐ 3	☐ 4
Standing	☐ 1	☐ 2	☐ 3	☐ 4
Walking	☐ 1	☐ 2	☐ 3	☐ 4
Watching TV	☐ 1	☐ 2	☐ 3	☐ 4
Working	☐ 1	☐ 2	☐ 3	☐ 4

SYMPTOMS:

Please check all that apply in **past 12 months.**

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Bed Wetting
- ❑ Blood Pressure (High or Low)
- ❑ Blurred Vision
- ❑ Broken Bones/Fractures
- ❑ Cancer
- ❑ Colon Trouble/Digestive Issues
- ❑ Depression
- ❑ Diarrhea/Constipation
- ❑ Difficulty Breathing
- ❑ Dizziness/Loss of Balance
- ❑ Double Vision
- ❑ Eating Disorder
- ❑ Epilepsy/Convulsions
- ❑ Fainting
- ❑ Foot or Knee Problems
- ❑ Frequent Colds/Flu
- ❑ Gall Bladder Trouble
- ❑ Headaches
- ❑ Hearing Loss
- ❑ Heartburn
- ❑ Heart Problem
- ❑ Hepatitis (A,B,C)
- ❑ Hormone Imbalance
- ❑ Impotence/Sexual Dysfunction
- ❑ Irritable
- ❑ Jaw pain/TMJ
- ❑ Kidney Trouble
- ❑ Learning Disability
- ❑ Liver Trouble
- ❑ Lung Problems
- ❑ Menopausal Problems
- ❑ Mood Changes
- ❑ Numb/Tingling arms, hands, fingers
- ❑ Numb/Tingling legs, feet, toes
- ❑ Osteoporosis
- ❑ Pain CHEST
- ❑ Pain HIP
- ❑ Pain LOW BACK
- ❑ Pain MID BACK
- ❑ Pain NECK
- ❑ Pain SHOULDER
- ❑ Pain UPPER BACK
- ❑ Painful Swollen joints
- ❑ Pregnant (now)
- ❑ Prostate Problems
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Sinus/Drainage Problem
- ❑ Skin Problems
- ❑ Swollen/Painful Joints
- ❑ Tremors
- ❑ Trouble Sleeping
- ❑ Tumors
- ❑ Ulcers

ARE YOU TAKING MEDICATIONS FOR ANY OF THE FOLLOWING:

❑ Acid Reflux	❑ Anxiety	❑ Cholesterol	❑ Hormone Therapy (HRT)	❑Thyroid
❑ ADD/ADHD	❑ Aspirin	❑ Crohns/Colitis	❑ Ibuprofen	❑Tylenol
❑ Allergy	❑ Birth Control	❑ CPAP machine	❑ Muscle Relaxer	❑_____
❑ Anti-biotics	❑ Blood Pressure	❑ Diabetes	❑ Pain Killer	❑_____
❑ Antidepressants	❑ Blood Thinner	❑ Headache	❑ Sleep	❑_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same complaint(s)? ❑ No ❑ Yes
   If Yes, whom? ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
2. Have they ever been treated for the same condition(s)? ❑ No ❑ Yes ❑ I don't know
3. Any other hereditary conditions the Doctor should be aware of? ❑ No ❑ Yes: If yes, Explain: _____

SOCIAL HISTORY:

1. Smoking: ❑ Cigars ❑ Pipe ❑ Cigarettes >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverages (Consumption): >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug Use: >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? _____
   _____

PHYSICAL STRESS:

1. Have you ever been in a car accident? ❑ No ❑ Yes - If yes when? _____
   a. What speed was the collision? ❑ 0 - 10 ❑ 10 - 20 ❑ 20 - 30 ❑ 40 - 50 ❑ 50+
   b. Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact ❑ Roll-Over
   c. Was treatment received? ❑ No ❑ Yes – If yes, explain: _____
2. Have you ever been injured at work? ❑ No ❑ Yes – If yes, explain: _____
   a. Was treatment received? ❑ No ❑ Yes – If yes, explain: _____
   b. Does your job require you to remain in long-term stressful postures? ❑ No ❑ Yes
      (*i.e. all day seating, repeated lifting, long-term computer use)*
3. Have you ever had any spinal traumas in the past? ❑ No ❑ Yes – If yes, explain: _____
   a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field (explain) :_____
   b. Trauma as a child: fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, sports injury (explain):_____
   c. Work around the house: (lifting, bending, woke up with stiff neck, "back went out") (explain): _____

STRESS PROFILE:

1. How many hours of sleep do you average per night? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑7 ❑ 8 ❑ 9 ❑ 10+
2. Do you have trouble falling asleep ❑ Wake up and can't fall back asleep ❑ Wake up exhausted like you never slept ❑
3. Do you ever take pills to go to sleep or relax? ❑ No ❑ Yes
4. Do you use a CPAP machine? ❑ No ❑ Yes
5. Do you often feel short on time and procrastinate on projects? ❑ No ❑ Yes
6. Do you feel like you don't give enough time to important areas in your life like family, personal , or a hobby? ❑ No ❑ Yes

CHEMICAL STRESS PROFILE:

1. Are you regularly exposed to cleaning products or industrial chemicals? ❑ No ❑ Yes
2. Have you ever noticed mold growing in your home or your place of work? ❑ No ❑ Yes
3. Does your home, work, school, or car have damp or mildew smell? ❑ No ❑ Yes

FITNESS PROFILE:

1. What type of exercise do you practice? ❑ Cardio ❑ Weight training ❑ Yoga ❑ Burst ❑ Organized sports ❑ Triathlons
2. Where do you workout? ❑ Gym ❑ Home ❑ Group Class ❑ Don't workout
3. How long do you exercise Minutes ❑ 0-30 ❑ 30-60 ❑ 60-90 ❑ 90+
4. How often do you exercise Days per Week ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. What is your goal? ❑ Weight ❑ Muscle ❑ Fitness ❑ Energy ❑ Image
6. What is your current weight? _____ What is your target weight? _____

NUTRITIONAL PROFILE:

1. Do you eat breakfast daily from Monday to Friday? ❑ No ❑ Yes
2. How many days per week do you skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
3. How many fast food, refined foods, or pre-pared meals do you eat per week? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
4. How many servings of fruit do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. How many servings of vegetables do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
6. Do you regularly drink (1 or more per day) ? (check all that apply) ❑ Soda ❑ Coffee ❑ Juice ❑ Milk ❑ Alcohol
7. Please list any supplements you take regularly: _____

   _____
8. Please list any allergies or sensitivities: _____

WHAT DO YOU FOCUS ON WHEN SELECTING FOODS?

(check all the apply):

- ❑ Calorie Content
- ❑ Fat Content (low fat diet)
- ❑ Ingredient list
- ❑ Sodium levels
- ❑ Artificial Sweeteners
- ❑ Ratio: Fat, Protein, Sugar
- ❑ Fat content (low fat)
- ❑ Nutrition data label
- ❑ Gluten content
- ❑ Pasteurization (milk)
- ❑ Glycemic Index
- ❑ Sugar content
- ❑ MSG content
- ❑ FDA food pyramid

WHAT TYPE OF FOOD DO YOU BUY?

(check all the apply):

- ❑ Organic Vegetables
- ❑ Grass-fed beef
- ❑ Wild-caught fish
- ❑ Non-GMO food
- ❑ Wild/Free range poultry
- ❑ Fresh fruit
- ❑ Healthy snacks
- ❑ Almond/coconut milk
- ❑ Water
- ❑ Regular Vegetables
- ❑ Grain-fed beef
- ❑ Farm raised fish
- ❑ GMO food/don't know
- ❑ Unknown source of poultry
- ❑ Canned Preserved fruit
- ❑ Junk food snacks
- ❑ Cow/soy milk
- ❑ Soda/Sweet tea/Coffee

DO YOU FOLLOW A NAMED DIET OR DOCTOR'S PLAN?

(check all the apply):

- ❑ Blood Type
- ❑ GAPS
- ❑ Paleo
- ❑ Raw Food
- ❑ Vegetarian
- ❑ Zone Diet
- ❑ Other _____
- ❑ Atkins
- ❑ Mediterranean
- ❑ Nutrisystem
- ❑ South Beach
- ❑ Volumetrics
- ❑ Weight Watchers
- ❑ None

WHAT DO YOU TYPICALLY EAT FOR BREAKFAST?

(check all the apply):

- ❑ Eggs
- ❑ Fruit
- ❑ Smoothie
- ❑ Vegetables
- ❑ Vegetarian
- ❑ Other_____
- ❑ Cereal
- ❑ Oatmeal
- ❑ Packaged meats
- ❑ Pastries
- ❑ Toast
- ❑ Other_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

_____

_____

_____

_____

HIPAA / Notice of Privacy Practice

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 1654). Patient confidentiality and privacy/security applies to and protected health information (PHI). Federal Laws now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

By signing this form, I acknowledge that I received or have been offered a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept at the front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

In order for the office to communicate with a family member, spouse, friend, or significant other by telephone, or verbally to a person who is in attendance with the patient in the doctor's office, the patient needs to authorize this communication. Any disclosure of protected health information (PHI) to another person requires this signed and dated authorization. If you have any aspects of your PHI that you do not want disclosed, please list the specific aspects of your PHI below that you want "restricted." This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing.

I authorize the doctor/staff to verbally communicate with the following person:

Name of Person: _____ Telephone number: _____

□ My complete health record

□ My complete health record, with the exception of the following information:
- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment

□ Other (please specify): _____

_____

Patient (or Representative) Signature Patient Name Date

_____

Patient Representative Name Relationship to Patient

AUTHORIZATION FOR USE OF NAME AND/OR PHOTOGRAPH FOR MARKETING PURPOSES

Our office may like to use your name and/or photograph for marketing purposes. Our office needs your signed and dated permission to use your name or photograph to be compliant with new HIPAA patient privacy federal laws. We love to share photos, stories, or progress on our Social Media page(s) or website in the interest of bringing wellbeing to new patients. This authorization may be revoked at any time, by advising our office of this revocation in writing.

□ YES, I authorize use of my name and/or photograph □ NO, I do not authorize use of my name and/or photograph

_____

Patient (or Representative) Signature Printed Name Date

INFORMED CONSENT - Chiropractic Adjustments, Modalities, and Therapeutic Procedures

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risks and hazards involved.

I have been advised that the chiropractic adjustments, modalities, and therapeutic procedures performed in this office, like all forms of health care, holds certain risks. While the risks are most often very minimal, there are some risks to exam and treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and increased symptoms/pain, or no improvement of symptoms/pain. I also acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Treatment objectives, as well as the risks associated with chiropractic adjustments and, all other procedures provided at Northwest Wellness Center have been explained to me to my satisfaction, and I have had an opportunity to ask questions. All my questions have been answered fully and satisfactorily, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the Doctor of Chiropractic named (and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named) deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

Patient (or Representative) Signature Patient Name Date

_____

Patient Representative Name Relationship to Patient

AUTHORIZATION FOR TREATMENT-THERAPY IN A MULTI-PATIENT AREA

All initial history, examination, and report of findings are done in a separate room in a confidential setting. However, our office utilizes treatment and therapy areas that allow for more than one patient to be present at the same time during a treatment session. This open area will allow patients to see each other and overhear what is being said and done. If you want to discuss anything that you do not want to be overheard, please inform the staff before you see the doctor so a private room can be arranged. Our office needs your authorization to treat you in this open area. If you do not authorize this, our office will make arrangements for your privacy. This authorization may be revoked by you at any time, by advising our office of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

□ **YES**, I authorize open treatment-therapy area □ **NO**, I desire to have treatment in a private setting

FINANCIAL POLICY

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on your account.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Northwest Wellness Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Northwest Wellness Center will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me, and I am personally responsible for payment.

_____

Patient (or Representative) Signature Printed Name Date

NORTHWEST WELLNESS CENTER 5728 Frantz Rd, Dublin, OH 43016 // (614) 792-3444

NOTICE OF PRIVACY PRACTICES

Effective: 1/1/14

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Northwest Wellness Center, (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's

involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers' Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 1, 2015.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice as follows:

Address: 5728 Frantz Rd, Dublin, OH 43016
Telephone: 614-792-3444 // Fax: 614-389-6444

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.