

HealthWise Chiropractic & Nutrition

Patient Intake Form

PATIENT INFORMATION

Date _____

Patient Name _____
Full Legal Name (First Middle Initial Last)

I prefer to be called _____

If patient is a minor, List parent's names:

Mother's Name Father's Name

Address _____

City _____ State _____ Zip _____

Email _____

Sex M F Birthdate ____/____/____ Age _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Employer/School _____

Spouse's Name _____

Spouse's Birthdate ____/____/____

How did you hear about HealthWise or whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____ Cell Phone (____) _____

Employer/School Phone (____) _____

Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

PAYMENT & ACCEPTANCE

The doctors and staff of **HealthWise Chiropractic & Nutrition** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

I understand and agree that the doctors of **HealthWise Chiropractic & Nutrition** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

I understand that all services rendered to me are my responsibility and that payment is expected at time of service.

Date _____ Signature _____

PERMISSION TO TREAT MINOR

I hereby authorize this office and its doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees that are charged by this office. I authorize ongoing treatment:

- Only when I am present Only if I am notified first
 At my child's discretion For _____ treatments

Signature _____ Date _____

ACCIDENT INFORMATION

Is your condition a result of an accident? Yes No
 If Yes, then what date did the accident occur? Date _____
 Where did it occur? Auto Work Home Other
 If Other, explain _____

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
 Attorney Name & Phone Number (If applicable) _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

What do you think the caused is? _____

Is this condition the Same Better Worse Unknown since it started?

Mark an "X" on the picture where you continue to have pain, numbness or tingling.

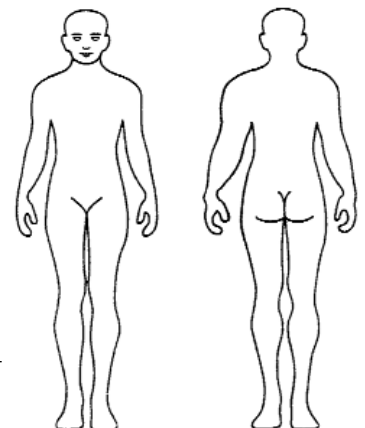
Rate your pain on a scale of 0 (no pain) to 10 (most pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramping Stiffness Swelling Other

How often do you have this pain? _____

Is the pain constant or does it come and go?

Does it interfere with your Work Sleep Daily Routine Recreation



TREATMENT OF CONDITION

What treatment have you already received for your current condition? None Surgery Medications Chiropractic Care
 Physical Therapy Other _____

List the names and specialty of the Doctor(s) who have treated for your condition _____

REVIEW OF SYSTEMS

Please check "NOW" for all conditions you are now experiencing and check "Past" for any condition you have experienced during your life.

| <u>GENERAL</u> | <u>NOW</u> | <u>PAST</u> | <u>NOW</u> | <u>PAST</u> | <u>NOW</u> | <u>PAST</u> | Number of Abortions _____ | |
|---------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|------------------------------|---------------------------|---|
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | Cold Intolerance | <input type="checkbox"/> | Last Period _____ |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Highly Emotional | <input type="checkbox"/> | Last Pap Smear _____ |
| Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Irritable & Restless | <input type="checkbox"/> | Last Mammogram _____ |
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Crave Salt | <input type="checkbox"/> | <u>ILLNESSES</u> |
| Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> | High Triglycerides | <input type="checkbox"/> | <input type="checkbox"/> | Hyperventilation | <input type="checkbox"/> | <u>NOW</u> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <u>PAST</u> |
| Head Trauma | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | AIDS / HIV <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting / Nausea | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | Anorexia <input type="checkbox"/> |
| Change in Vision | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Suicidal Thoughts | <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Glasses / Contacts | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Suicide Attempt | <input type="checkbox"/> | Bulimia <input type="checkbox"/> |
| Redness of eyes | <input type="checkbox"/> | <input type="checkbox"/> | Bloating | <input type="checkbox"/> | <input type="checkbox"/> | Extreme Worry | <input type="checkbox"/> | Cancer <input type="checkbox"/> |
| Watering of eyes | <input type="checkbox"/> | <input type="checkbox"/> | Belching | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Problems | <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Hard of Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain | <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Gas | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Weakness | <input type="checkbox"/> | Heart Disease <input type="checkbox"/> |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Cramps | <input type="checkbox"/> | Hepatitis <input type="checkbox"/> |
| Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> | Black Stools | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | Herpes <input type="checkbox"/> |
| Nose Bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Herniated Disk | <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> |
| Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Disease | <input type="checkbox"/> | <input type="checkbox"/> | Fractures | <input type="checkbox"/> | Leukemia <input type="checkbox"/> |
| Stiff Neck | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Dislocations | <input type="checkbox"/> | Mononucleosis <input type="checkbox"/> |
| Bleeding Gums | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | Ligament Trauma | <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> |
| Canker Sores | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Pacemaker <input type="checkbox"/> |
| Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Dribbling | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Parasites <input type="checkbox"/> |
| Mercury Fillings | <input type="checkbox"/> | <input type="checkbox"/> | Increased Urination | <input type="checkbox"/> | <input type="checkbox"/> | <u>FEMALES ONLY</u> | | Parkinson's Disease <input type="checkbox"/> |
| Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | Decreased Urination | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Itching | <input type="checkbox"/> | Rheumatoid Arthritis <input type="checkbox"/> |
| Tonsils Removed | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Discharge | <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Trouble Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Infection | <input type="checkbox"/> | <input type="checkbox"/> | Painful Intercourse | <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Breast Lumps | <input type="checkbox"/> | <input type="checkbox"/> | Genital Infection | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Periods | <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Breast Pain | <input type="checkbox"/> | <input type="checkbox"/> | Impotency | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Cramps | <input type="checkbox"/> | Tumors, Growths <input type="checkbox"/> |
| Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | Hot Flashes | <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy | <input type="checkbox"/> | Yeast Infections <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Strokes | <input type="checkbox"/> | <input type="checkbox"/> | Ovaries Removed | <input type="checkbox"/> | Other _____ |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sensation | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | <input type="checkbox"/> | <u>CHILDHOOD DISEASES</u> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Poor Coordination | <input type="checkbox"/> | <input type="checkbox"/> | Contraception Type _____ | Due Date _____ | Birth Defects <input type="checkbox"/> |
| Heart Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> | Age at First Period _____ | | Chicken Pox <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hand Trembling | <input type="checkbox"/> | <input type="checkbox"/> | Duration of Cycle _____ | | Measles <input type="checkbox"/> |
| Cold Feet / Hands | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | (Between 28-45 days) | | Mumps <input type="checkbox"/> |
| Swelling in Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | Duration of Flow _____ | | Polio <input type="checkbox"/> |
| Swelling in Hands | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | (Between 1-7 days) | | Rheumatic Fever <input type="checkbox"/> |
| Calf Pain | <input type="checkbox"/> | <input type="checkbox"/> | Change in Appetite | <input type="checkbox"/> | <input type="checkbox"/> | # of Pregnancies _____ | | Rubella <input type="checkbox"/> |
| Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | Heat Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | Number of Births _____ | | Scarlet Fever <input type="checkbox"/> |
| | | | | | | Number of Miscarriages _____ | | |

HISTORY OF INJURIES / SURGERIES

Approximate Date(s) & Description

Car Accidents _____
Surgeries _____
Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Other Injuries _____

Please list the locations of **ALL** scars on your body (major and minor ones): _____

Please list the locations of **ALL** tattoos and piercings on your body: _____

MEDICATIONS

List all medications and why you are taking them.

VITAMINS / HERBS

List all vitamins / supplements and why you are taking them.

ALLERGIES

List all allergies to medications, pollens, foods, etc.

SOCIAL HISTORY

Do you drink Alcoholic beverages? Never Rarely Weekly Daily How many per week? _____
Do you drink coffee? Never Occasionally Often If so, how many cups per day? _____
Do you smoke cigarettes? Never Occasionally Often Number of packs per day? _____ for _____ years
Do you have stress? Yes No Rate your average stress level on a scale from 0-10 ____ Reason _____
Hours you sleep at night? ____ What time do you usually go to bed? ____ Describe sleep problems, if any _____
Are you sexually active? Yes No With multiple partners? Yes No _____
Have you ever contracted any sexually transmitted diseases? Yes No If yes, list _____

DIET & EXERCISE

Exercise: Never Light Moderate Heavy Hours per week: _____ Type: _____
Physical work: Never Light Moderate Heavy Hours per day: _____ Type: _____
Mental work: Never Light Moderate Heavy Hours per day: _____ Type: _____

I eat fast food Never Daily Weekly Monthly I consume dairy Never Daily Weekly Monthly
I drink soda Never Daily Weekly Monthly I eat vegetables Never Daily Weekly Monthly
I eat fruit Never Daily Weekly Monthly I eat raw seeds or nuts Never Daily Weekly Monthly
I eat fish Never Daily Weekly Monthly I eat food with sugar Never Daily Weekly Monthly

List the three worst foods you eat during an average week: _____, _____, _____
List the three healthiest foods you eat during an average week: _____, _____, _____

GOALS & LIMITATIONS

What are the goals you would like to achieve being treated in this office? _____

What limitations do you have, if any, in working with the Doctors in this office in achieving optimal health (i.e. Unwilling to take nutritional supplements or herbs, won't give up smoking or alcohol. etc.)? _____

HealthWise Chiropractic & Nutrition Case History for Pregnant Mothers

Prenatal history:

1) Is this your first pregnancy? Y N

2) How many other births have you had? _____

3) How many weeks pregnant are you now? _____

4) Have you experienced any traumas during this pregnancy? (accidents, falls) Y N

Please describe _____

5) Any medications taken during this pregnancy? Y N

Describe why the Medications were prescribed: _____

6) Do you smoke or drink alcohol? Y N How often? Daily Weekly Monthly

Comments: _____

7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling) ?

Please list dates, frequency and reason for these procedures:

8) Please describe your diet been during this pregnancy?(ie: foods you crave, foods you avoid, typical breakfast, lunch, dinner and snacks, fast food etc.) _____

9) Has there been any stressful events in your life during this pregnancy? Y N

If Yes, Explain: _____

10) What are your most significant fears associated with this birth? _____

11) Who is your birth care provider? _____

Contact Phone Number: _____

12) Will you have someone with you at birth for support? (other than birth care provider) Y N

Please specify who _____

13) Where do you plan on delivering? _____

14) Have you put together a birth plan? Y N

If not, would you like assistance? Y N

Comments: _____

Previous Birth History

Date: _____

- 1) **Place of birth:** hospital / birthing center / home
2) **Delivering Practitioner:** OB/Gyn / Certified Nurse Midwife / Certified Practicing Midwife / Lay Midwife
3) **Position of Delivery:** Lithotomy position (on back with feet up) / On Your Side / Kneeling / Squatting
Other? _____

- 4) **Was labor induced?** (Contractions were stimulated prior to the natural onset of labor)
Yes No Unknown

Comments: _____

If yes, specify type: Pitocin, Prostaglandin Gel (applied to your cervix), Unknown

- 5) **Were your membranes ruptured by your care provider?** Yes No Unknown
6) **Were contractions stimulated intravenously with pitocin once labor started?** Yes No Unknown
7) **Did you receive any pain medications or anesthesia?** Yes No Unknown

Please specify type used _____

If you had an epidural, how many centimeters were you dilated when it was administered? _____

- 8) **Did you experience back pain during labor?** Yes No Unknown
9) **Did you deliver vaginally?** Yes No
10) **Baby presentation at time of delivery:** Normal / Posterior / Brow / Facial / Breech
If breech, specify type: Footling / Frank / Complete / Kneeling

- 11) **Was there any visible injury to your baby?** Yes No Unknown
If so, where on your baby was the injury sustained? _____

- 12) **Did your care provider assist delivery with his/her hands?** Yes No Unknown
13) **Was there any turning of the neck, or traction (pulling) applied to the neck?** Yes No Unknown
14) **Were operative devices used used to facilitate the birth?** Yes No Unknown

Which type? Forceps / Vacuum Extraction

If yes, was there any visible signs of injury to your baby? Yes No Unknown

If yes, where was the injury sustained?

- 15) **Was there a birthing coach present?** husband / doula / friend / other
If other, please specify: _____

- 16) **At what week of pregnancy was your baby born?** _____

- 17) **Were you able to breastfeed your baby?** Yes No

Please include any additional comments: _____

Thank you!

HealthWise Chiropractic & Nutrition

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physical therapy, exercises and nutritional supplementation may also be used as part of the treatment. During the manipulation/adjustment the doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you experience when you "crack" your knuckles. You may feel or sense movement.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware, as with any health care procedure, there are certain complications which may arise during a chiropractic manipulation/adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain and myelopathy. Some patients may feel some stiffness and soreness following the first few days of treatment.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with the one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may susceptible to that kind of injury. The other complications are also generally described as "rare."

There are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. The practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Other treatment options for your condition include self administered, over-the-counter analgesics, medical care with prescription drugs, naturopathic remedies including homeopathy, herbs, vitamins and minerals, home exercises and stretches and dietary changes.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

| | | |
|--|--------------|---------------|
| Signature of Patient | Printed Name | Date and time |
| Signature of Parent or Guardian (if a minor) | Printed Name | Date and time |
| Signature of Witness | Printed Name | Date and time |

NOTICE OF PRIVACY PRACTICES

HealthWise Chiropractic & Nutrition
Mark Flannery, D.C. & Vera Flannery, D.C.
1919 Williams St. #250, Simi Valley, CA 93065

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.

Our Pledge Regarding Your Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will

be listed. However, we have listed all of the the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES OF INFORMATION AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Notification: In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities requires by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share you medical information if it is necessary to prevent a serious threat to your health or safety of the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information

concerning identification and location of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.)
4. Request that we communicate with you about your medical information by different means or to different locations. You request that we communicate your medical information to you by different means or different locations must be made in writing to the contact person listed at the end of this notice.
5. Request the we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change information we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

Contact Person

Dr. Mark Flannery
1919 Williams St.
Simi Valley, CA 93065
Tel: (805) 991-7455

I, _____,
Hereby acknowledge receipt of the Notice of
Privacy Practices given to me.

Signed: _____

Date: ____/____/____

If not signed, reason why acknowledgement
was not obtained: _____

Staff Witness seeking acknowledgement

Signed: _____

Date: ____/____/____