Confidential Intake Form

All information you supply is confidential. We comply with all federal privacy standards.

Reason for visit (mark circle)

- ◯ Work Injury -> Date of Injury (DOI): _____ Claim #: _____
- ◯ Auto Injury -> Date of Injury (DOI): _____ Claim #: _____
- ◯ Other (you will describe below)

PRO-FORM CHIROPRACTIC & SPORTS INJURY

_____ Today's Date (mm/dd/yyyy)

_____ Who referred you/how did you find out about us?

Previous chiropractic, physical therapy, massage therapy or acupuncture care? ◯ Yes ◯ No

_____ Date of last visit (approx)

_____ Your full name | _____ Preferred Name | _____ Birth date (mm/dd/yyyy) | _____ Age

Gender (for insurance) ◯ Male ◯ Female

Gender (if applicable) ◯ M2F ◯ F2M Pronoun Preference (if applicable) ◯ she/her ◯ he/him ◯ they/them

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

_____ Spouse's Name

_____ Mailing address | _____ E-mail address

_____ City | _____ State/Province | _____ ZIP/Postal Code | _____ Cell phone ◯ OK to leave Voicemail?

E-Communication: (you may opt out at any time) Our providers may communicate with you via text or email. We also provide convenient email and text appointment reminders and invoice options. Do you agree to receive? ◯ **Yes** ◯ **No**

_____ Emergency contact name | _____ Relationship | _____ Telephone

Employment Details

_____ Your occupation | _____ Your employer | _____ Work Telephone

_____ Work address | _____ City | _____ State/Province | _____ ZIP/Postal Code

Family (PCP) and/or Specialist Doctor (if applicable)

_____ Primary care physician (Family doctor) | _____ Clinic | _____ Telephone | _____ Fax

_____ Specialist | _____ Clinic | _____ Telephone | _____ Fax

**If you would prefer us to NOT communicate with your PCP regarding care, mark "No" and initial: ◯ No Initials: _____

_____ Preferred Pharmacy | _____ Pharmacy Telephone

_____ Pharmacy Address

Insurance Information

_____ Insured's name | ____ /____ /_____ Insured's date of birth | _____ Insured's employer

_____ Primary Policy Holder | ____ /____ /_____ Primary's date of birth | _____ Relation to Insured

_____ Insurance company | _____ Member ID # (include alpha prefix) | _____ Group #

_____ Insurance company's address | _____ City | _____ State/Province | _____ ZIP/Postal Code

©1. List your current complaints using the keys below.

- **Indicate the area/complaint.**
- **Mark the average and worst intensity**
- **Mark the frequency.**
- **Mark the circles according to "quality" (the sensation)**

Key:

- **Intensity** (0-10): 0 -> none /10 -> highest conceivable intensity)
- **Frequency:** (1-4):

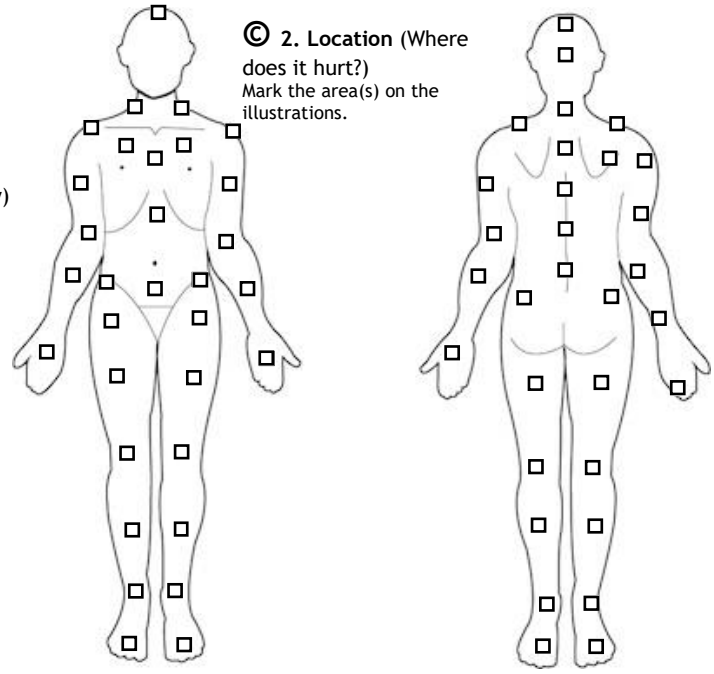
(1) Occasional (0-25% of time) (2) Intermittent (26-50% of time)
(3) Frequent (51-75% of time) (4) Constant (76-100%)

	Ave. Pain	Worst Pain	Freq.
1. _____	Choose	Choose	Choose
2. _____	Choose	Choose	Choose
3. _____	Choose	Choose	Choose
4. _____	Choose	Choose	Choose

Symptoms:

◯ Achiness	◯ Numbness	◯ Tightness	◯ Cramping
◯ Nagging	◯ Tingling	◯ Stiffness	◯ Stabbing
◯ Swollen	◯ Burning	◯ Soreness	◯ Sharp
	◯ Shooting	◯ Throbbing	◯ Dull

© 2. Location (Where does it hurt?)
Mark the area(s) on the illustrations.



©3. Have you ever suffered from your current symptoms in the past? ◯**Yes** ◯**No** If yes, explain:

Year	Cause	Tests done?	Problem resolved completely?
			◯**No** ◯**Yes**
			◯**No** ◯**Yes**
			◯**No** ◯**Yes**

©4. Have you received any evaluation and/or treatment for your current condition(s)? ◯**Yes** ◯**No** If yes, explain:

Month/Year	Doctor or therapist	Recommended treatment	Outcome (if applicable)

©5. Please list any other special diagnostic tests that you have had in the past year: _____

_____

_____

6. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯	Grocery shopping	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯	Household chores	◯	◯	◯	◯
Standing	◯	◯	◯	◯	Lifting objects	◯	◯	◯	◯
Walking	◯	◯	◯	◯	Reaching overhead	◯	◯	◯	◯
Lying down	◯	◯	◯	◯	Showering or bathing	◯	◯	◯	◯
Bending over	◯	◯	◯	◯	Dressing myself	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯	Love life	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯	Getting to sleep	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯	Staying asleep	◯	◯	◯	◯
Driving car	◯	◯	◯	◯	Concentrating	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯	Gardening/Yard work	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯	Exercising	◯	◯	◯	◯
Work duties	◯	◯	◯	◯	Athletics/Recreation	◯	◯	◯	◯

Past personal, family and social history Please identify your past health history, including accidents, injuries, illnesses and treatments.

7. Have you ever been hospitalized or had surgery? ◯No ◯Yes If yes, describe:

Year	Reason	Surgery	Outcome

8. Have you ever had any traumas or accidents? (Falls, car accidents, work injury, sports injury, fractures) ◯No ◯Yes If yes, describe:

Year	Trauma	Treatment	Outcome

9. Do you take any medications or supplements (including over the counter eg.Tylenol?) ◯No ◯Yes If yes, describe:

Name	Reason	x/day	Dose	Since when?

10. Do you have any allergies? ◯No ◯Yes If yes, list:

11. Family History

Some health issues are hereditary. Is there a history of illness (cancer, arthritis, heart disease, depression, diabetes, etc.) in your immediate family?

FAMILY

Relative	Age (If living)	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	_____	_____	_____	◯	◯
Father	_____	_____	_____	◯	◯
Other: _____	_____	_____	_____	◯	◯
Other: _____	_____	_____	_____	◯	◯

12. Social History

SOCIAL

Sleep (check all that apply): ☐ Restful sleep ☐ Snore heavily ☐ Sleep < 6h
☐ Difficulty Falling asleep ☐ Sleep Face down ☐ Sleep 6-8h
☐ Wake up frequently ☐ Grind teeth at night (bruxism)? ☐ Sleep > 8h

How often do you exercise: ◯ Don't ◯ About 1x/week ◯ 2-3x/week ◯ > 3x/week ◯ Daily

Water intake: ◯ <33oz(1L) ◯ 33-50oz (1-1.5l) ◯ >50oz(1.5L)

Alcoholic Drinks: ◯ Never ◯ <1/day ◯ Daily ◯ 6-10/week ◯ >10/week

Caffeine use: ◯ Never ◯ <1/day ◯ Daily ◯ 6-10/week ◯ >10/week Source of caffeine: _____

Tobacco use: ◯ No ◯ <1x/day ◯ <½ pack/day ◯ >½ pack/day ◯ >1 pack/day Type of tobacco: _____

Soft drinks: ◯ Never ◯ <1/day ◯ Daily ◯ 6-10/week ◯ >10/week

What vitamins/supplements do you take? ☐ Not taking ☐ Glucosamine ☐ Chondroitin ☐ Calcium ☐ Multi-Vitamin ☐ Fish Oils
☐ Pro-biotics ☐ Magnesium ☐ Greens ☐ B Complex ☐ Vitamin C ☐ Vitamin D ☐ Vitamin E
Others: _____

Describe your eating habits: ◯ Skip breakfast ◯ Two meals per day ◯ Three meals per day ◯ Snacking between meals

Diet restrictions/intolerances: _____

Rate your fatigue level (0-10): _____ /10

Rate overall stress level (0-10): _____ /10

What are major causes of stress? ◯ Work ◯ School ◯ Economic ◯ Family/Relationships

Hobbies: _____

13. Review of systems

Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've **HAD** or currently **HAVE**:

a. HEENT
- ☐ Blurred Vision
- ☐ Floaters in vision
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Glaucoma
- ☐ Ear infections
- ☐ Sinusitis
- ☐ Nasal Polyps
- ☐ Strep Throat
- ☐ Mononucleosis
- ☐ **None**

b. Integumentary
- ☐ Dry Skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Hair Loss
- ☐ Rash
- ☐ Melanoma
- ☐ **None**

c. Respiratory
- ☐ Asthma
- ☐ Apnea
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ COPD
- ☐ Allergies
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ **None**

d. Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Pins and needles
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Mood Disorders
- ☐ **None**

e. Digestive
- ☐ Ulcer
- ☐ Anorexia/Bulimia
- ☐ Food Sensitivities
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Celiac
- ☐ Diverticulitis/osis
- ☐ Gas/Bloating
- ☐ Gall Bladder Disease
- ☐ **None**

f. Endocrine
- ☐ Thyroid Issues
- ☐ Hypoglycemia
- ☐ Immune Disorders
- ☐ Low Energy
- ☐ Swollen glands
- ☐ Frequent Infection
- ☐ Polycystic Ovarian Syndrome
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Goiter
- ☐ **None**

g. Genitourinary
- ☐ Kidney Stones
- ☐ Prostate Issues
- ☐ Erectile Dysfunction
- ☐ Bedwetting
- ☐ PMS Symptoms
- ☐ Infertility
- ☐ Urinary Tract infections
- ☐ Yeast Infections
- ☐ Abnormal PAP
- ☐ STD's
- ☐ Decreased Libido
- ☐ **None**

h. Constitutional
- ☐ Fainting
- ☐ Low Libido
- ☐ Poor Appetite
- ☐ Difficulty losing weight
- ☐ Weakness
- ☐ Sudden Weight Change
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ **None**

i. Cardiovascular
- ☐ Angina
- ☐ High-cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Excessive Bruising
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Murmurs
- ☐ A-Fib
- ☐ Heart Disease
- ☐ **None**

j. General
- ☐ Cancer
- ☐ Epilepsy
- ☐ AIDS/HIV
- ☐ Alcoholism/Drug dependence
- ☐ Gout
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Typhoid
- ☐ Malaria
- ☐ Post-Nasal Drip

- ☐ Other:
- ☐ Other:
- ☐ Other:

14. What would be the most significant thing that you could do to improve your health? _____

_____

15. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

FOR MEDICARE ONLY

1. At the present, would you describe your health as: ◯ Excellent ◯ Very good ◯ Fair ◯ Poor

2. Who do you currently live with? (or intend to live with at the conclusion of this therapy?)

◯ Alone ◯ w/Spouse or Partner ◯ w/Children/Relative ◯ w/Personal Care Attendant ◯ Other: _____

3. Where do you currently live (or intend to live) at the conculsion of this therapy?

◯ Private home ◯ Private apartment ◯ Rented room ◯ Group home ◯ Board and care apartment ◯ Assisted living ◯ SNF

4. Were you discharged from an inpatient, SNF, or home health treatment within the last 30 days? ◯ Yes ◯ No

5. Do you need this plan of care/therapy to return to a previous, or move into a new, living environment? ◯ Yes ◯ No

6. What other condition are you currently being treated for? Do you require any durable medical equipment (bath bench, wheelchair, cane, etc.) for these conditions?

_____

_____

7. "ADLs" are "activities of daily living" such as eating, bathing, dressing and toileting. What is your current level of independence with these activities?

◯ Maximal assistance (you provide 50% of the effort)
◯ Moderate assistance (you perform 50-75%)
◯ Minimal assistance (require incidental hands-on help)
◯ Supervision Only (require standby assistance only)
◯ Modified Independence (require a device but no physical help)
◯ Complete independence

8. "IADL's" are activities such as cooking, driving, using telephone and shopping. What is your current level of independence with these activities?

◯ Maximal assistance (you provide 50% of the effort)
◯ Moderate assistance (you perform 50-75%)
◯ Minimal assistance (require incidental hands-on help)
◯ Supervision Only (require standby assistance only)
◯ Modified Independence (require a device but no physical help)
◯ Complete independence

Erisa Agreement

Assignment of Health Plan Benefits and Rights as well as an appointment and/or designation as my personal representative and an ERISA/PPACA Representative and beneficiary:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Pro-Form Chiropractic and Sports Injruy as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Patient Signature Date

_____

Patient Name

© Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, acupuncture and/or chiropractic manipulations on me (or the patient named below, for whom I am legally responsible) by any licensed clinicians who, now or in the future, treat me while employed by, work or are associated with, or are serving as a replacement or locum, for any Pro-Form Chiropractic and Sports Injruy clinic, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the clinicians, and/or with other office or clinic personnel, the nature and purpose of all recommended procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, acupuncture and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the Pro-Form clinician to be able to anticipate and explain all risks and complications, I wish to rely on the Pro-Form clinician to exercise judgment during the course of the procedures which the Pro-Form clinician deems necessary and, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to evaluation and treatment at Pro-Form Chiropractic and Sports Injruy. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ Date _____

Patient Signature

_____

Patient Name

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

_____ Date _____

Representative Signature

_____

Representitive Name

© Records Request Authorization

I understand and authorize all Pro-Form clinics to request health information regarding my condition(s) while under treatment at Pro-Form. Pro-Form Chiropractic and Sports Injury may request any of the following, as long as it pertains to the treatment and care rendered at Pro-Form Chiropractic and Sports Injury, from the entities that I disclose.

- Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

This authorization can be withdrawn by me at any time.

_____ _____

Patient Signature Date

_____

Patient Printed Name

Insurance Authorization Agreement

Your health insurance plan may now require **"authorization"** for some services (these may include one or all of the following: Chiropractic, Massage, Physical Therapy, and Acupuncture).
The number of annual visits for the above-mentioned services that are "allowed" by your plan may not have changed, however your insurance company **now uses an outsourced (3rd party) company to decide what is "medically necessary" and, in turn, what they will pay for**.

You may have received notification from your insurance company however such policies can be confusing and because we value your trust in us we want to you to be aware of the reasons and processes involved.

The Authorization Process

1. **Appointment with provider:** The information required by your insurance company to apply for authorization can only be gathered from a normal appointment with your provider.
2. **Care Plan and Treatment:** you and your provider agree on the need for care and begin treatment.
3. **Submission:** Pro-Form will submit the required paperwork for you based on the information gathered at your in-office visit.
4. **Authorization:** When authorization is granted it will specify (1) the number of visits and (2) the time frame allowed to use those. When the allowed visits are used or the time period expires a new authorization must be submitted. NOTE: this will apply regardless of the annual limits that your plan carries.

Denials and Patient Responsibility

If a submission is not immediately approved it will go to **"medical review"**. It may take days or weeks for the insurance company to get back to us with a determination of approval or denial. If your case does go to **medical review** we will inform you so that you can make a decision to continue with care or wait until we receive the response.

Should you choose to receive care:

- Any visits that your insurance deems to lack "medical necessity" will become your financial responsibility. This is standard practice for any services rendered that are not covered by insurance. We always strive to keep you informed about where we are in the process of obtaining authorization.

- Due to the time sensitive nature of this process If you do not provide us with accurate insurance information and we are unable to obtain pre-authorization on your behalf then you may be responsible for the visit if we are unable to appeal.

- You cannot have two authorizations on file at the same time. If a past office has an active authorization file you will need to contact them to add a discharge date before the date of your first visit with us. If this is not done we will be unable to obtain pre-authorization and you will be responsible for any visits not approved.

- Please discuss with your provider if you believe you may have an authorization on file at a different clinic or have questions about this process. Any visits that your insurance does not pay for due to this issue will be your responsibility.

We continue to be a leader on researching and managing these new systems to get you the best care possible. Unfortunately, this new cost saving strategy by your insurance company simply makes it more difficult for you to utilize your insurance policy benefits.

Please let us know if you have any questions or concerns. We are here to help and do our best to make sure that you receive the care you need. Thank you.

Patient Signature _____ Date_____

Printed Name _____

NOTE: If you are one of the many health insurance customers who feel that this new policy is an unreasonable barrier to getting care we encourage you to make this known by contacting your employer (HR), your insurance carrier and the Insurance commissioner. All complaints to the commissioner must be investigated and will hopefully lead to a change in regulation.

Call or send your letter:
Consumer Protection Services
Office of the Washington State Ins. Commission
P.O. Box 40256
Olympia, WA 98504-0256
Tel: (800) 562-6900

©

HIPAA Agreement

(Notice of Privacy Practices Acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature _____ Date: _____

Patient Name _____

Representative/Gaurdian Signature _____ Date: _____

Representative/Guardian Name _____

Office use only

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:

HIPAA Agreement

(Patient Copy)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy