Welcome to Core Wellness Chiropractic and Naturopathic Clinic, LLC!

It is my goal as a Naturopathic Physician to assist you in achieving your optimal level of wellness. This is a different level for everyone, however feeling good, better or best comes down to a few fundamentals.

Our promise to every patient is to address basic fundamentals that need to be handled in order for optimal healing to occur. This may include addressing possible nutritional deficiencies and lack of physical conditioning. If it is deemed that you are in need of further Naturopathic workup or hormonal/immune support you will be given the names of great doctors who specialize in just that. It all effects how you heal. We are committed at Core Wellness Clinic to bringing you the most up-to-date advances that regenerative medicine has to offer. We appreciate the trust that you have put into working with us.

If you are in it to win it and ready to put in the work to optimize your healing capacity, then you are in the right place!

All of the nutritional supplements, hormones and treatments in the world mean very little if you, as the patient, are not committed to making the appropriate lifestyle changes to achieve your optimal wellness. We simply cannot fight “bad chemistry” (in the form of inflammatory foods, lack of exercise, etc) with more chemistry (supplements, drugs, hormones).

**Poor dietary, exercise, sleep & lifestyle habits + pills/prescriptions ≠ Good Health**

We believe completely that without the proper fundamentals of how you nourish, move and treat your body that we will not get the best results with injection therapy. The building blocks are essential.

Our ultimate goal is to address the root causes of what is holding you back from your optimal wellness!

---

### You are in the right place IF
- You are ready to take responsibility for yourself
- You are ready to explore feeling your best!
- You are willing to make the diet and exercise changes necessary to optimize your tissues.
- You are willing to read the materials prescribed
- You are ready to shed the reality of who you WERE and accept the reality of who you can become.
- You are ready to adopt Conscious Eating
- Understand that this process is NOT a brief, quick fix with a pill or magic injection
- Understand that this process takes 3-6 treatments, at the minimum, to get you to a maintenance level.

### You are NOT in the right place IF:
- You are not ready to invest in your body/health emotionally and financially
- You believe that you are not responsible for your current state of health
- You believe that you can not control what/how you eat
- You are not willing to meet 1-3 times with our Nutritional Therapist one-on-one in addition to our office visits if it is deemed necessary
- You are not willing to consider re-vamping your exercise routines if deemed necessary
- You are not willing to undertake a detox/cleanse if necessary
OFFICE POLICIES

Please initial each line below showing that you understand our Office Policies:

_____Appointments: We request that new patients arrive 15 minutes prior to their scheduled appointment time so that we can verify all of your forms. Because we hold a special appointment time just for you, we ask that you call in advance if you need to change your appointment. **For new patients we require 2 business days (48 hr) notice. For established patients we ask 1 business day (24 hrs) notice.** We understand that emergencies come up on both sides of this issue – Drs. and Patients - but we try to accommodate everyone’s needs in the scheduling process. We do collect deposits on Platelet Rich Plasma and Stem Cell treatments to hold your appointment slot.

Your New Patient fee, that you have already paid, will go towards a rescheduled new visit if your first appointment was cancelled without proper notice, it will essentially act as a credit when you reschedule. There is a $60 late cancellation fee for established patients. We will charge this to the card that we put on file when you schedule your appointment. Please call the clinic within the appropriate cancellation time frame above at 503-644-4446.

_____Medicare does not acknowledge nor pay for any Naturopathic medical services.

_____Please complete your New Patient Packet PRIOR to your appointment and please arrive 15 min prior to your scheduled arrival time. If your paperwork is not completed by the scheduled time of your appointment you may be rescheduled and a late cancellation fee will be applied. We pride ourselves at keeping on schedule. If you are more than 15 minutes late you will be rescheduled and a late cancellation fee applied (see above).

_____Payment: Payment is expected at the Time of Service. We accept Cash, Checks, Credit and Debit cards. There is a $25.00 fee for Returned Checks, PLUS any bank fee charges we incur.

_____Insurance: Dr Moore does not accept nor participate with Private Insurance. We do create appropriate Superbills which are itemized invoices that you may send to insurance or health savings medical plans for reimbursement. If your insurance company requests chart notes or any other information there is a handling fee of $15. If a Prior Medication Authorization is needed, a fee for Dr. Moore’s time will be charged to the patient.

_____Labs: If you would like to utilize your health insurance to pay for labs then you must verify your benefits before your first visit. If you prefer, we do offer significantly reduced rates on blood work through a lab co-op (up to 80% discount), payment is required at time of lab order. Lab result interpretation requires an appointment as Dr. Moore will need to interpret and discuss results with you directly. We may require some basic lab work before your will be treated with injection therapy. **You will always be given a copy of your lab results. Please DO NOT misplace these. If you do misplace them and need further copies a fee may be applied.**

_____Primary Care: We practice medicine with the intent of assisting our patients to achieve their highest level of pain relief. The focus is not on acute or primary care, or chronic pain medication management. Dr. Moore does not provide acute care services or act as a Primary Care Physician. Dr. Moore will work with you to optimize your overall wellness, however we do ask that you retain your relationship with your Primary Care Doctor.
Medicinal Items/Sales: Dr. Moore makes nutraceutical/supplement recommendations based solely on medical need. Some of the supplements we carry at CWC can be found elsewhere and on the internet at a different price, however the quality of those products is unknown. We do not participate in price matching if you find it for a lower price elsewhere. We cannot guarantee quality standards or potency of products purchased elsewhere. We do not grant refunds on nutraceuticals/supplements if they have been opened. Payment is due at the time of purchase on all medical supplies, nutraceuticals and supplements.

Email: Email is not generally an ideal way to conduct medicine, nor an appropriate way to handle prescription refill requests or any Urgent Matters. Please do not email the Doctors or the clinic for these matters, always call the Front Desk. Dr. Moore is not available for email discussions about treatment, please ALWAYS contact the front desk via phone. It is a HIPAA violation for our office to even receive emails regarding treatment plans/prescriptions/care as our systems are NOT encrypted.

Phone Calls: Proper understanding of instructions is important for all patients. Every attempt is made to give each patient a clear treatment plan and needed handouts as well as to answer all questions at the time of the visit. After reading your treatment plan and handouts, if you have further questions, please call the front office to clarify. Additionally, please let us know of concerning changes in symptoms, adverse side effects or concerns after treatment. Calls of a non-urgent matter will be responded to within 1 business day, urgent calls will be responded to as soon as we receive them. If you are having an emergency please call 911 or head to your nearest emergency room.

Please sign below and date to acknowledge that you have clearly read over, understand and agree to our Office Policies.

Signature: ___________________________________________  Date: ___________________________
NEW PATIENT INFORMATION

Last Name: ___________________________  First: _____________________________  M.I.: _________

Address: ______________________________________________________________________________

City: _____________________________  State: ____________________ Zip Code: _____________

Home #: __________________  Work #: ______________________  Cell #: _______________________

Marital Status: Single  Domestic Partner  Married  Divorced  Widow/er

Birthday: ____/____/____  Age: ___________  Gender: Male  Female

Email: ______________________________________  Referred by: _____________________________

Primary Care Physician’s Name & #: ____________________________  Permission to Contact: Y or N

Occupation: _____________________________________  Employer: ______________________________

Spouse or Guardian or Emergency Contact:

Last Name: _____________________ First Name: _______________________  Relationship: ____________

Cell #: ______________  Work #: _____________________  Other #: _______________________

Responsible Party: (Complete this section if you are not the patient but are responsible for the account)

Name: ____________________________________  Relationship to Patient: _________________

Address: ______________________________________________________________________________

City: ________________________________  State: ____________________  Zip Code: ________________

Home #: ________________________  Work #: ________  Cell #: __________________

Financial Policy

In the interest of good health care practice, it is desirable to establish a financial policy to avoid misunderstandings. All accounts are payable in full at the time of service. We accept cash & checks, as well as most major Credit Cards. A $30 charge will be imposed for all returned checks. Any missed or cancelled appointments without 24 hrs notice will be charged as outlined above in our office policies.

Payment is expected at time of service. Patients will be supplied with a Super Bill and are encouraged to submit their own claims.

Dr. Moore does not accept, nor is she In-Network, with any Private Health Insurance Companies. Medicare does not acknowledge nor cover Naturopathic Physician visits.

Prior to doctor filling out any special forms, a fee of $15.00 will be collected from the patient. (i.e.Disability, Private forms, Time Loss, Letters for HSA, etc.)

I have read this policy and understand that I am responsible for payment at the time of each office visit. This includes all Naturopathic/Chiropractic Therapies, Office Visits, Procedures, Nutritional Supplements and some Laboratory Charges.

**If I am a Motor Vehicle patient I understand that I am ultimately responsible for any balance due on my account that my insurance company does not pay.**

Signature: _________________________________________________  Date: ____________________________
### NEW PATIENT HEALTH HISTORY

**Name:** ___________________________  
**Todays Date:** ___________________________

- **Reason for visit today:**  
  - [ ] Past Falls/Accidents (w/dates): ___________________________  
  - [ ] Past Broken Bones/Dislocations/Head Injuries (w/dates): ___________________________
  - [ ] Past Surgeries (w/dates): ___________________________

#### Neck, Back, Extremities: [Check (✓) CURRENT Symptoms & (X) PAST Symptoms]

<table>
<thead>
<tr>
<th>NECK</th>
<th>ARMS &amp; HANDS (specify R or L)</th>
<th>HIPS, LEGS &amp; FEET (specify R or L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o pain in neck</td>
<td>o weakness of arm</td>
<td>o instability/weakness in knee</td>
</tr>
<tr>
<td>o neck stiffness</td>
<td>o numbness in arm</td>
<td>o instability/weakness of leg</td>
</tr>
<tr>
<td>o neck weakness</td>
<td>o pins &amp; needles in fingers</td>
<td>o leg cramps</td>
</tr>
<tr>
<td>o muscle spasm in neck</td>
<td>o pins &amp; needles in arms</td>
<td>o leg cramps</td>
</tr>
</tbody>
</table>

**SHOULDERS** (specify R or L)

| o can’t raise arms | o pain in upper arm |
| o Overhead above shoulders | o pain in elbow |
| o pain across shoulders | o pain in forearm |
| o tension in shoulders | o pain in hand |
| o pain in shoulder joint | o pain in fingers |

**LOW BACK**

| o muscle spasms in low back |

**MID-BACK**

| o muscle spasms in mid-back | o low back weakness |
| o pain between shoulder blades | o low back stiffness |
| o mid-back stiffness | o inability to bend |

**TOP 3 Activities Limited by PAIN:**

1. ___________________________
2. ___________________________
3. ___________________________

#### Below please mark either “C” for Currently or “Y” for Yes, but resolved (Leave the remaining conditions BLANK)

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>CARDIOVASCULAR</th>
<th>MUSCULOSKELETAL</th>
<th>NEUROLOGIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Diabetes</td>
<td>o Lymphedema</td>
<td>o Bone &amp; Joint Disease</td>
<td>o Vertigo</td>
</tr>
<tr>
<td>o Cancer</td>
<td>o Blood Clots</td>
<td>o Tendonitis</td>
<td>o Fainting</td>
</tr>
<tr>
<td>o Loss of Sleep</td>
<td>o Varicose Veins</td>
<td>o Bursitis</td>
<td>o Dizziness</td>
</tr>
<tr>
<td>o Fatigue</td>
<td>o High/Low Blood Pressure</td>
<td>o Arthritis</td>
<td>o Epilepsy/Seizures</td>
</tr>
<tr>
<td>o Dental Problems</td>
<td>o Heart Condition</td>
<td>o Swollen Joints</td>
<td>o Falls/Loss of Balance</td>
</tr>
<tr>
<td>o Jaw Pain/TMJ</td>
<td>o Bleeding Disorder</td>
<td>o Painful Joints</td>
<td>o Sleep Disorder</td>
</tr>
<tr>
<td>o Hepatitis</td>
<td>o Heart Condition</td>
<td>o Muscle Aches/Soreness</td>
<td>o Numbness/Tingling</td>
</tr>
<tr>
<td>o Sinus Trouble</td>
<td>o Organ Systems:</td>
<td>o Scoliosis (type?)</td>
<td>o Chronic Pain</td>
</tr>
<tr>
<td>o PM</td>
<td>o Wheezing/Asthma</td>
<td>o Headache</td>
<td>o Herpes/Shingles</td>
</tr>
<tr>
<td>o Infectious Disease</td>
<td>o Kidney Disease</td>
<td>o Skin</td>
<td>o Headache</td>
</tr>
<tr>
<td>Name ___________________________</td>
<td>o Liver Disease</td>
<td>o Scars, Location:</td>
<td>o Headache</td>
</tr>
<tr>
<td>o Depression</td>
<td>o Familial History</td>
<td>o Itching</td>
<td>o HAIR</td>
</tr>
<tr>
<td>o Weight Loss/Gain</td>
<td>o Diabetes</td>
<td>o Athlete’s Foot/Rashes</td>
<td>o Hair Loss, none</td>
</tr>
<tr>
<td>o Eating Disorders</td>
<td>o Cancer</td>
<td>o Skin Cancer</td>
<td>o Smoking, none</td>
</tr>
<tr>
<td>o Lung Disease</td>
<td>o Local Anesthetic</td>
<td>o Constipation</td>
<td>o Alcohol</td>
</tr>
<tr>
<td>o High Blood Pressure/Stroke</td>
<td>o Other:</td>
<td>o Gas/Bloating</td>
<td>o Exercise, none</td>
</tr>
<tr>
<td>o Other:</td>
<td>o Allergies</td>
<td>o Diverticulitis</td>
<td>o 1-2 x week</td>
</tr>
<tr>
<td>o Other:</td>
<td>o Drugs, Specify:</td>
<td>o IBS/IBD</td>
<td>o 3-5 x week</td>
</tr>
</tbody>
</table>

**PAST IMAGING/STUDIES DONE OF PAINFUL REGION:**

**CURRENT MEDICATIONS (NAME, DOSE, WHY):**

**VITAMINS/HERBS/SUPPLEMENTS:**

**WHAT ARE YOUR TREATMENT GOALS?**

Core Wellness Clinic, LLC  
10200 SW Eastridge St, Ste 135, Portland, OR 97225  
503.644.4446
CONDITION SPECIFIC HISTORY

LOCATION OF PAINFUL/INJURED AREAS (reason for visit today): ____________________________________________________________

ONSET (When did this condition start?): __________________________________________________________________________

MODIFYING FACTORS:
What makes BETTER? ____________________________________________________________________________________________
What makes WORSE? ____________________________________________________________________________________________
(Consider things like position, hot/cold, medications you’ve tried, going up/down stairs or hills, etc)

ASSOCIATED SYMPTOMS:
Does this pain move? Does it go down/up an arm or leg? Past the elbow or knee? 
Do you get a headache or limb pain with it? Popping/Clicking/Instability? 
Consider all other symptoms that go along with your condition(s) that brings you in today 
___________________________________________________________________________________________________________________________________________

TIMING:
What time of day is your pain at it’s worst? __________________________________________________________________________
Better or worse first thing in AM? ________________________________________________________________________________
Better or worse after prolonged sitting? ____________________________________________________________________________
Better or worse after using joint? _________________________________________________________________________________
Better or worse after exercise? _________________________________________________________________________________
Better or worse at end of day? ________________________________________________________________________________
Do you have discomfort in any one position for too long (sitting, standing, lying)? Y/N 

TREATMENTS YOU HAVE TRIED FOR THIS CONDITION:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Y/N</th>
<th>Helpful?</th>
<th>Y/N</th>
<th>Past/Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Past/Current</td>
</tr>
<tr>
<td>Chiropractic?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Past/Current</td>
</tr>
<tr>
<td>Massage?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Past/Current</td>
</tr>
<tr>
<td>Acupuncture?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Past/Current</td>
</tr>
<tr>
<td>Cortisone Injections?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Dates: _____________</td>
</tr>
<tr>
<td>Ibuprofen?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Dose: _____________</td>
</tr>
<tr>
<td>Tylenol?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Dose: _____________</td>
</tr>
<tr>
<td>Supplements?</td>
<td>Y/N</td>
<td>Helpful?</td>
<td>Y/N</td>
<td>Specify: _____________</td>
</tr>
</tbody>
</table>

LAST TIME YOU HAD LAB WORK RAN? _____________
Any abnormal values, inflammation, kidney or liver issues, thyroid issues? (circle if yes)
McGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM
(Reproduced with permission of author © Dr. Ron Melzack, for publication and distribution)

Name: _____________________________________ Date: ____________

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throbbing</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Shooting</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Stabbing</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Sharp</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Cramping</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Gnawing</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Hot-burning</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Aching</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Heavy</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Tender</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Splitting</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Tiring-Exhausting</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Sickening</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Fearful</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Cruel-Punishing</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

Mark or comment on the above figure where you have your pain or problems.

Indicate on the line below how bad your pain is:
(At the left end of line means no pain at all, at right end means worst pain possible)

No Pain ____________________________________________________________________ Worst Possible Pain
**SLEEP HEALTH HISTORY**

Name: ________________________________  Date: __________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven’t done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** dose
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

*It is important that you answer each question as best as you can.*

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and Reading</td>
<td>__________</td>
</tr>
<tr>
<td>Watching TV</td>
<td>__________</td>
</tr>
<tr>
<td>Sitting, inactive in a public place (ie. theater, meeting)</td>
<td>__________</td>
</tr>
<tr>
<td>As a passenger in a car for an hour w/out a break</td>
<td>__________</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>__________</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>__________</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>__________</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>__________</td>
</tr>
<tr>
<td>Do you find yourself waking at night? Y/N If yes, at that time?</td>
<td>__________</td>
</tr>
<tr>
<td>Do you have a hard time falling asleep? Y/N Staying asleep? Y/N</td>
<td></td>
</tr>
<tr>
<td>Does your pain wake you? Y/N Do you snore? Y/N</td>
<td></td>
</tr>
<tr>
<td>Do you wake up feeling refreshed? Y/N Spouse snore? Y/N</td>
<td></td>
</tr>
</tbody>
</table>

Core Wellness Clinic, LLC 10200 SW Eastridge St, Ste 135, Portland, OR 97225 503.644.4446
INFORMED CONSENT for CORE WELLNESS CLINIC, LLC

I hereby consent to Naturopathic and/or Chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by Tyna Moore, ND, DC and/or other licensed doctors of chiropractic or naturopathic who now or in the future provide other types of treatment for me. This consent includes other doctors that are employed by, associated with, or serve as back-up for Tyna Moore, ND, DC whether or not their names are listed on this form.

I understand and consent to the following procedures if deemed appropriate: physical examination, tests, physiotherapy, physical medicine, physical therapy procedures, myotherapy, common diagnostic procedures, dietary advice and therapeutic nutrition, trigger point injections, prolotherapy, injection therapy, botanical/herbal medicines, prescribing of various nutritional therapeutic substances including plant, mineral, and animal materials, hydrotherapy, counseling, vitamin and mineral intramuscular injections, intravenous therapy and/or prescription medications/hormones.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic and/or naturopathic treatments. Those complications include but are not limited to: pain, discomfort, bruising, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, pneumothorax, infiltration, fractures, disc injuries, dislocations, muscle strain, Homers’ syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations, allergic reactions to prescribed medications and/or nutritional supplements and herbs or aggravation of pre-existing symptoms. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I acknowledge that Dry Needling is not the same procedure as Acupuncture.

I understand that Dr. Moore reserves the right to terminate the doctor/patient relationship if I am non-compliant with the treatment plan and/or if a conflict of interest arises. Due to her concern of potentially incurring a needle stick, I understand that Dr. Moore has a policy of choosing not to inject Hepatitis C or HIV positive patients.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic and/or naturopathic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the treatments. I state that I have been informed and weighed the risks involved in chiropractic/naturopathic treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

______________________________
Printed name of Patient

x

Signature of Patient

______________________________
Date

______________________________
Signature of Representative

x

(if patient is a minor or is handicapped)

______________________________
Date

Core Wellness Clinic, LLC 10200 SW Eastridge St, Ste 135, Portland, OR 97225 503.644.4446
Notice of Privacy Practices and Consent Form

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 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: Dr. Tyna Moore.

- The right to request restriction 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 a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove.
- The right to reasonable request 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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of Jan 1st, 2008 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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, and payment of 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_________________________________________
Signature:_____________________________________________
Relationship to Patient:_________________________________
Date:____________