Lower Bucks
Total Health and
Wellness Center, P.C.

NEW CHIROPRACTIC PATIENT INTAKE FORM

Name_____**Date**_____

Address_____**City**_____**State**_____**Zip**_____

Telephone_____**Email Address**_____

Age_____ **Birthdate**___/____/_____ **Gender** M/F **Marital Status** M S D W

Referred By (*If Any*)_____

Occupation_____ **Employer**_____

Years Employed_____**Work Phone**_____**Ext**_____

Is your condition due to a motor vehicle or work related accident? YES / NO _____
If Yes, have you filed a claim with your auto insurance or worker's compensation? YES / NO

Attorney's Name (*if applicable*)_____**Telephone**_____

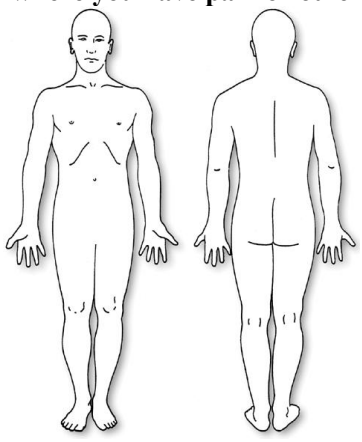
Emergency Contact_____**Telephone**_____

Date your problem began _____/_____/_____

Please describe how your problem began

_____
_____
_____
_____

Mark an X where you have pain or other symptoms



How bad is your pain? 0 1 2 3 4 5 6 7 8 9 10
No Pain Excruciating Pain

Describe your pain/symptoms (circle all that apply) Sharp/Stabbing Throbbing Achy Dull Soreness Weakness Numbness Tingling Burning Shooting Other _____

How often are your symptoms present? Constantly / Frequently / Occasionally

Since your problem began, your condition is improving / has not changed / is getting worse

What makes the problem better? (circle all that apply) Nothing Lying Down Walking Standing Sitting Movement Inactivity/Rest Other _____

What makes the problem worse? (circle all that apply) Nothing Lying Down Walking Standing Sitting Movement Inactivity/Rest Other _____

Can you perform your daily activities? Yes / Yes, but only with help / No

Have you seen another health care professional or had any treatment for this problem prior to your coming to our office today? YES / NO
If YES, what type of treatment?

_____
_____
_____
_____

Have you had any X-rays, MRI or other tests for this condition? YES / NO
If YES, what tests and when?

_____
_____
_____
_____

Are you presently taking any medications (including birth control)? YES / NO
If YES, list the medications you are taking below

_____
_____
_____
_____

Have you had any recent or previous hospitalizations or surgical procedures? YES/NO
If YES, please list dates and procedures below

_____
_____
_____
_____

Health History

Please mark an X next to any symptoms you are presently experiencing as well as any symptoms listed below that you have had in the past. Knowledge of these conditions may influence the type of treatment you receive at our office.

Present	Past	Condition
____	____	Neck Pain
____	____	Shoulder Pain (R/L)
____	____	Upper Arm/Elbow Pain (R/L)
____	____	Hand/Wrist Pain (R/L)
____	____	Upper Back Pain
____	____	Lower Back Pain
____	____	Hip/Upper Leg Pain (R/L)
____	____	Knee Pain (R/L)
____	____	Lower Leg Pain (R/L)
____	____	Ankle/Foot Pain (R/L)
____	____	Jaw Pain
____	____	Fainting
____	____	Epilepsy/Convulsions
____	____	Visual Disturbances
____	____	Headaches
____	____	Tinnitus (Ringing in Ears)
____	____	Rapid Heart Rate
____	____	Loss of Appetite
____	____	Anorexia
____	____	Asthma
____	____	Abnormal Weight Gain/Loss
____	____	Diabetes
____	____	Excessive Thirst
____	____	Frequent Urination
____	____	Chronic Cough
____	____	Chronic Sinusitis
____	____	General Fatigue
____	____	Irregular Menstrual Cycle
____	____	Irregular Menstrual Flow
____	____	PMS
____	____	Loss of Bladder Control
____	____	Abdominal Pain
____	____	Constipation
____	____	Irregular Bowel Habits
____	____	Difficulty Swallowing
____	____	Heartburn/Indigestion

Present	Past	Condition
____	____	Depression
____	____	Aortic Aneurysm
____	____	Hypertension
____	____	Chest Pain
____	____	Chest Pain
____	____	Heart Attack (Date)_____
____	____	Stroke (Date)_____
____	____	Cancer_____
____	____	Prostate Problems
____	____	Blood Disorder
____	____	Lung Disorder_____
____	____	Arthritis
____	____	Rheumatoid Arthritis
____	____	Ulcer
____	____	Liver/Gallbladder Problems
____	____	Hepatitis
____	____	Kidney Disorders (stones, etc)
____	____	Bladder Infection
____	____	HIV/AIDS

Family History

____ Cancer ____ Diabetes
____ Hypertension ____ Arthritis
____ Heart Problems ____ Lung Problems
____ Headaches ____ Back Problems

Do you have a permanent Disability Rating?

YES/NO

Location_____
Rating Percentage_____
Date Rating Was Received _____

Please Check All That Apply to You

____	____	Tobacco
____	____	Alcohol
____	____	Drug/Alcohol Dependence
____	____	Coffe/Tea/Caffinated Soft Drinks

Cups/Cans Per Day_____

Height____'____ **Weight**_____

I certify that the information I have provided is complete and accurate to the best of my knowledge. I agree to notify this office immediately when I have changes in my health condition.

Patient's Signature _____**Date** _____

Parent/Guardian **MUST** sign for all patients under 18 years of age

INSURANCE INFORMATION

Patient Name_____**Date**_____

Insurance Carrier_____

Insurance ID#_____**Group** #_____

ATTENTION MEDICARE PATIENTS

Please notify us if your Social Security Number is different from your Medicare ID number

Subscriber's Name_____

Subscriber's Date of Birth_____

Subscriber's Employer_____

Relation to Subscriber SELF SPOUSE DEPENDENT

I understand and agree that I am responsible for payment of any services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

Patients with group or individual insurances are responsible for any unpaid balance in the event that their insurance does not cover chiropractic care or is terminated while they are under care at this office.

I fully accept full responsibility and I release the Lower Bucks Total Health and Wellness Center, Inc. and its doctors from any and all liability in the unlikely event that a problem occurs from my treatment. By signing below, I affirm that the provided information above is correct and consent to chiropractic care at this office.

_____

Patient's Name (print)

_____

Patient's Signature **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- ☐ **I stay at home most of the time because of my back.**
- ☐ **I change position frequently to try and get my back comfortable.**
- ☐ **I walk more slowly than usual because of my back.**
- ☐ **Because of my back, I am not doing any jobs that I usually do around the house.**
- ☐ **Because of my back, I use a handrail to get upstairs.**
- ☐ **Because of my back, I lie down to rest more often.**
- ☐ **Because of my back, I have to hold on to something to get out of an easy chair.**
- ☐ **Because of my back, I try to get other people to do things for me.**
- ☐ **I get dressed more slowly than usual because of my back.**
- ☐ **I stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **My back is painful almost all of the time.**
- ☐ **I find it difficult to turn over in bed because of my back.**
- ☐ **My appetite is not very good because of my back pain.**
- ☐ **I have trouble putting on my socks (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of back pain, I get dressed with help from someone else.**
- ☐ **I sit down for most of the day because of my back.**
- ☐ **I avoid heavy jobs around the house because of my back.**
- ☐ **Because of back pain, I am more irritable and bad tempered with people than usual.**
- ☐ **Because of my back pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

Shoulder Pain and Disability Index (SPADI)

Please place a mark on the line that best represents your experience during the last week attributable to your shoulder problem.

Pain scale

How severe is your pain?

Circle the number that best describes your pain where: 0 = no pain and 10 = the worst pain imaginable.

At its worst?	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10

Disability scale

How much difficulty do you have?

Circle the number that best describes your experience where: 0 = no difficulty and 10 = so difficult it requires help.

Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
Washing your back?	0	1	2	3	4	5	6	7	8	9	10
Putting on an undershirt or jumper?	0	1	2	3	4	5	6	7	8	9	10
Putting on a shirt that buttons down the front?	0	1	2	3	4	5	6	7	8	9	10
Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10
Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Carrying a heavy object of 10 pounds (4.5 kilograms)	0	1	2	3	4	5	6	7	8	9	10
Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10

CARPAL TUNNEL QUESTIONNAIRE

Name _____ Number _____ Date _____

How severe is the hand or wrist pain that you have at night?
☐ I do not have hand or wrist pain at night
☐ Mild pain
☐ Moderate pain
☐ Severe pain
☐ Very severe pain

How often did hand or wrist pain wake you up during a typical night in the past two weeks?
☐ Never
☐ Once
☐ Two or three times
☐ Four or five times
☐ More than five times

Do you typically have pain in your hand or wrist during the daytime?
☐ I never have pain during the day
☐ I have mild pain during the day
☐ I have moderate pain during the day
☐ I have severe pain during the day
☐ I have very severe pain during the day

How often do you have hand or wrist pain during the daytime?
☐ Never
☐ Once or twice a day
☐ Three to five times a day
☐ More than five times a day
☐ The pain is constant

How long on average does an episode of pain last during the daytime?
☐ I never get pain during the day
☐ Less than 10 minutes
☐ 10 to 60 minutes
☐ Greater than 60 minutes
☐ The pain is constant throughout the day

Do you have numbness (loss of sensation) in your hand?
☐ No
☐ I have mild numbness
☐ I have moderate numbness
☐ I have severe numbness
☐ I have very severe numbness

Do you have weakness in your hand or wrist?
☐ No weakness
☐ Mild weakness
☐ Moderate weakness
☐ Severe weakness
☐ Very severe weakness

Do you have tingling sensations in your hand?
☐ No tingling
☐ Mild tingling
☐ Moderate tingling
☐ Severe tingling
☐ Very severe tingling

How severe is the numbness (loss of sensation) or tingling at night?
☐ I have no numbness or tingling at night
☐ Mild
☐ Moderate
☐ Severe
☐ Very severe

How often did hand numbness or tingling wake you up during a typical night during the past two weeks?
☐ Never
☐ Once
☐ Two or three times
☐ Four or five times
☐ More than five times

Do you have difficulty with the grasping and use of small objects such as keys or pencils?
☐ No difficulty
☐ Mild difficulty
☐ Moderate difficulty
☐ Severe difficulty
☐ Very severe difficulty

Reference: Levine et al. A Self- Administered Questionnaire for the Assessment of Severity of Symptoms and Functional Status in Carpal Tunnel Syndrome. The Journal of Bone and Joint Surgery 1993; 75-A(11):1585-1592.

Lower Bucks
Total Health and
Wellness Center, P.C.

NOTICE OF PRIVACY PRACTICES

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.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health information to other health care professionals within our practice for the purpose of treatment, verifying insurance benefits, payment and/or health care operations.

example

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Lower Bucks Total Health and Wellness Center, P.C.

It is our policy to provide a substitute health care provider, authorized by Lower Bucks Total Health and Wellness Center, P.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to sickness, vacation or an emergency situation.

Payment

We may disclose your health information to your insurance provider for the purposes of payment or health care operations.

example

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Lower Bucks Total Health and Wellness Center, P.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services rendered."

Workers' Compensation

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Appointment Reminders

As a courtesy to our patients, we may send you appointment reminders in the forms of phone calls, text messages or emails. If we call and you are not there or you do not answer, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed in any of these reminder formats other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Fundraising and Marketing

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc throughout the year. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, dates and times and request your participation in such events. It is not our policy to disclose any personal health information about your condition for the purpose of Lower Bucks Total Health and Wellness Center, P.C. sponsored fundraising events."

Change of Ownership

In the event that Lower Bucks Total Health and Wellness Center, P.C. is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to your requested restriction(s).

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information

- You have a right to request that Lower Bucks Total Health and Wellness Center, P.C. amend your protected health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Lower Bucks Total Health and Wellness Center, P.C.

- You have the right to request a paper copy of this Notice of Privacy Practices at any time.

Changes to This Notice of Privacy Practices

Lower Bucks Total Health and Wellness Center, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future and will make provisions effective for all information that it maintains. Until such amendment is made, Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to comply with this notice.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice, or if you want more information about your privacy rights, please call Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

Complaints

Complaints about your privacy rights or how Lower Bucks Total Health and Wellness Center, P.C. has handled your health information should be directed to Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of

__11__/__1__/__14__

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Lower Bucks Total Health and Wellness Center, P.C. with my authorization and consent to use and my disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____

Patient's Signature **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

_____

Authorized Facility Signature **Date**