Vibrance
Chiropractic & Wellness Center, LTD
We Heal Naturally

Please fill out the following form in as much detail as possible. Please print. Date _____Patient ID#_____

First Name_____MI_____Last Name_____DOB_____Age_____SS#_____-____-_____
Address_____ State_____ Zip_____
Home # (_____)_____Cell # (_____)_____Work#(_____)_____
Occupation_____ Employer_____
Insurance Company_____Insured Name:_____Insurance ID/Policy#_____
Marital Status S M D W Spouse Name_____
Is this visit due to □Auto Accident □Worker's Comp □Personal Injury? Who may we thank for referring you?_____
Is any other member of your family being treated in this office? □Yes □No Names_____

Email:_____(email will NOT be shared with any 3rd parties, and is used for office newsletters & promotions only)

Have you ever had chiropractic care before? □Yes □No For what problem?_____

Were the results satisfactory? □Yes □No Describe:_____

Do you know what chiropractic techniques were used, if so describe:_____

Medical History:

1. Family physician's name _____Medical Group:_____

   Address: _____Phone:_____Fax:_____
2. Have you had any of the following tests done recently? Please give approximate dates.

   Blood tests _____Urinalysis _____MRI _____CT Scan _____Ultrasound _____

   Radiation Treatment _____ X-Ray examination _____Other special treatment _____

   At what hospital or office were these tests taken _____Name of doctor who ordered tests _____
3. ***If a Woman:*** Last menstrual period _____Do you have any reason to believe that you may be pregnant? □Yes □No
4. Are you allergic to anything you are aware of? _____
5. Are you presently taking any medication, herbs, vitamins, or over the counter products (aspirin included)? □Yes □No

   If yes, name them_____

   _____

   _____
6. Have you ever had any auto accidents, fallen down stairs or ladders, or other physical trauma in your lifetime? □Yes □No

   Please Describe:_____
7. Have you ever broken any bones or dislocations? □Yes □No Please Describe:_____
8. Please list all hospitalizations and surgeries along with the dates and reasons:_____

   _____

   _____
9. Do you have any surgical implants (pacemaker, knee or hip replacements, breast implants, etc)? □Yes □No

   Please Describe:_____
10. Do you exercise regularly? □Yes □No What kind of exercise? _____

    _____

11. Present Complaint/Reason for Seeking Care in this Office:_____

_____

12. Pain or Problem started on_____

13. How do you believe your problem (pain) began? _____

_____

14. How often is the complaint/pain present? Constant Frequent Intermittent Occasional Infrequent

15. Have you ever had this condition before or a similar condition? □Yes □No When?_____

16. Pains are: □Sharp □Dull/ Ache □Constant □Intermittent □Other_____

17. Does this pain shoot, radiate, or travel to other areas of your body? Where?_____

18. Are you experiencing numbness or tingling in any area of your body? Where?_____

19. What activities/positions aggravate your condition/pain?_____

20. What activities/positions lessen your condition/pain?_____

21. Is this condition worse during certain times of the day?_____

22. How often do you find yourself suffering from this problem? Every day Few times/week Few times/month Few times/yr

23. How long does the problem last? All day Few hours Minutes Seconds

24. Is this condition interfering with □Work? □Sleep? □Routine? □Other?_____

25. Other Doctors/Professionals seen for this condition_____

Describe the type of treatment _____

Diagnosis of previous physician _____Length of time under care_____Results _____

Use this space for any additional information you may wish to discuss _____

_____

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

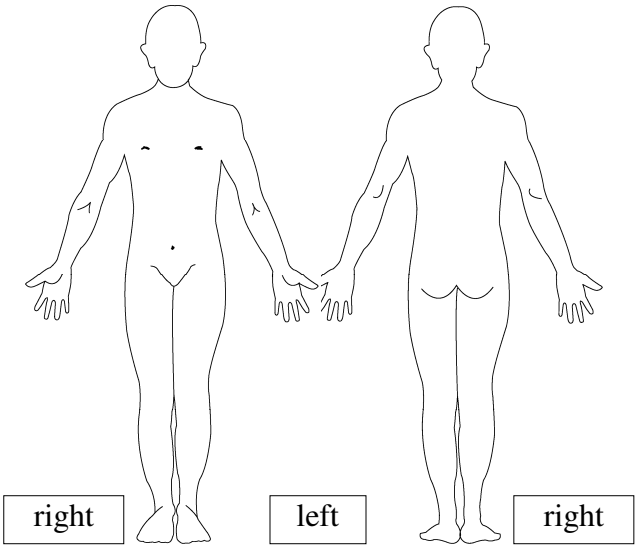
Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows: (_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows: (_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows: (_____)
0 10
no pain severe pain

Please mark on the diagram below the area of discomfort.
▼



Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now (within the past 12 months) or P if you ever had these conditions in the past.

General
____Fever
____Chills
____Night Sweats
____Loss of Sleep
____Fatigue
____Nervousness
____Weight Loss
____Weight Gain
____Allergies
____Bleeding Problems
____Anemia
____Diabetes
____Cancer
____HIV Risk Factors

Eye, Ear, Nose, Throat
____Poor Vision
____Pain in Eyes
____Difficulty Hearing
____Nosebleeds
____Sinus Trouble
____Dental Problems
____Hoarseness
____Tonsillectomy

Gastrointestinal
____Poor Appetite
____Poor Digestion
____Difficulty Swallowing
____Belching or Gas
____Frequent Nausea
____Vomiting
____Vomiting Blood
____Pain Over Abdomen
____Ulcer
____Black/Bloody Stool
____Liver Problems
____Gall Bladder Problems
____Jaundice
____Hernia
____Diarrhea
____Constipation
____Hemorrhoids
____Appendicitis

Women Only
____Live Births
____Miscarriage
____Painful Periods
____Excessive Flow
____Irregular Cycles
____Vaginal Burning/Itching
____Hot Flashes
Date of Last Menstrual Period____
Date of Last Pap____
Date of Last Mammogram____

Respiratory
____Difficulty Breathing
____Chronic Cough
____Spitting Phlegm
____Spitting Blood
____Wheezing/Asthma
____Pneumonia
____Tuberculosis

Cardiovascular
____Irregular Heart Beat
____High Blood Pressure
____Pain Over Heart/In Chest
____Previous Heart Trouble
____Ankle Swelling
____Varicose Veins
____Rheumatic Fever
____Stroke

Genitourinary
____Frequent Urination
____Painful Urination
____Blood in Urine
____Kidney Disease
____Urinary Infection
____Inability to Control Urination
____Difficulty Starting Urine Flow
____Urinate ___times per night
____Breast Lump or Pain
____Venereal Infection/STD
____Sexual Difficulties

Skin
____Itching
____Bruising Easily
____Change in Moles
____Skin Cancer

Neurologic
____Weakness
____Twitching
____Tremors
____Headache
____Migraines
____Fainting
____Dizziness/Vertigo
____Convulsions
____Epilepsy
____Numbness/Tingling
____Arm/Leg Pain
____Mental Disorder

Men Only
____Testicular Pain/Swelling
____Prostate Problems

Accidents/Trauma
____Motor Vehicle Accidents
____Other Trauma/Accidents

Musculoskeletal
____Neck Stiffness/Pain
____Pain Between Shoulders
____Low Back Pain
____Swollen Joints
____Painful Joints
____Muscle Aches/Soreness
____Spinal Curvature
____Arthritis

Childhood Diseases
____Measles
____Mumps
____Chicken Pox

Does any member of your family have any of the following? Please include mother, father, aunts, uncles, grandparents, brothers, sisters.

YES	NO	CONDITION	PLEASE NOTE WHICH FAMILY MEMBERS ARE AFFECTED.
☐	☐	HEART DISEASE OR HEART ATTACK	
☐	☐	HIGH BLOOD PRESSURE	
☐	☐	KIDNEY OR BLADDER DISEASE	
☐	☐	TUBERCULOSIS	
☐	☐	DIABETES	
☐	☐	EMOTIONAL OR MENTAL DISORDER	
☐	☐	STROKE, BLOOD CLOTS OR PHLEBITIS	
☐	☐	BLOOD VARIATIONS (SICKLE CELL, THALASSEMIA, G6PD)	
☐	☐	BIRTH DEFECTS, DOWN SYNDROME, NEURAL TUBE DEFECTS	
☐	☐	HEMOPHILIA	
☐	☐	MUSCULAR DYSTROPHY OR CYSTIC FIBROSIS	
☐	☐	HUNTINGTON CHOREA	
☐	☐	TAY-SACHS DISEASE	
☐	☐	TWINS OR MULTIPLE BIRTHS	
☐	☐	CANCER	
☐	☐	CHRONIC ILLNESSES	
☐	☐	DRUG ABUSE	
☐	☐	MAJOR OPERATIONS	
☐	☐	PREGNANCY COMPLICATIONS	
☐	☐	DID YOUR MOTHER TAKE ANY HORMONES WHILE CARRYING YOU?	

Is there any other significant family history for your family that is not listed above? Please describe:_____

_____

_____

Habits: (please check):

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

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PATIENT NAME:_____FILE NO:_____

WELCOME

The doctors and staff of **Vibrance Chiropractic & Wellness Center** 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.

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Vibrance Chiropractic & Wellness Center** 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 if information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____

Date Patient Signature

INSURANCE

This office will process your insurance claims upon request. We do our best to provide sufficient information to your insurance carrier to obtain payment for your treatment. We have found that, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made by your insurance carrier, you are responsible to pay your account in full.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ _____

Date Patient Signature

PATIENT IDENTIFICATION

_____
Name

_____
Street

_____
City, State and Zip

_____
Social Security #

Male ( ) Female ( )

Name or Nickname I prefer to be called in this office _____

Telephone (Home) _____

(Work) _____

Ok to call there? Yes ( ) No ( )

Ok to leave a message there? Yes ( ) No ( )

Ok to identify ourselves to those answering phone? Yes ( ) No ( )

Contact in case of emergency: Name: _____Telephone # _____

Name of Parent of Minor Patient (If applicable) _____

NECK DISABILITY INDEX: PLEASE COMPLETE FOR NECK PAIN

Name:_____ Date:_____ File #:_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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.
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 with no pain in my neck.
I can read as much as I want with slight pain in my neck.
I can read as much as I want with moderate pain in my neck.
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 due to pain.

SECTION 5 – Headaches

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

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 not do any work at all.

SECTION 8 – Driving

I can 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 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 mildly disturbed (1-2 hrs sleepless).
My sleep is moderately disturbed (2-3 hrs sleepless).
My sleep is greatly disturbed (3-5 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 neck pain.
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

PERCENTAGE DISABILITY:_____%

OSWESTRY INDEX QUESTIONNAIRE: PLEASE COMPLETE FOR LOW BACK PAIN

Name:_____ Date:_____ File #:_____

This questionnaire is designed to help us better understand how your back pain affects your ability to manage daily activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present situation.

SECTION 1 - PAIN INTENSITY

- ❑ **My pain is mild to moderate. I do not need pain killers.**
- ❑ **The pain is bad, but I manage without taking pain killers.**
- ❑ **Pain killers give complete relief from pain.**
- ❑ **Pain killers give moderate relief from pain.**
- ❑ **Pain killers give very little relief from pain.**
- ❑ **Pain killers have no effect on the pain.**

SECTION 2 - PERSONAL CARE

- ❑ **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 causing extra pain.**
- ❑ **I can lift heavy weights, but it gives me extra pain.**
- ❑ **Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.**
- ❑ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- ❑ **I can lift only very light weights.**
- ❑ **I cannot lift or carry anything at all.**

SECTION 4 – WALKING

- ❑ **I can walk as far as I wish.**
- ❑ **Pain prevents me from walking more than 1 mile.**
- ❑ **Pain prevents me from walking more than 1/2 mile.**
- ❑ **Pain prevents me from walking more than 1/4 mile.**
- ❑ **I can walk only if I use a cane or crutches.**
- ❑ **I am in bed or in a chair for most of every day.**

SECTION 5 – SITTING

- ❑ **I can sit in any chair for as long as I like.**
- ❑ **I can sit in my favorite chair only, but for as long as I like.**
- ❑ **Pain prevents me from sitting for more than 1 hour.**
- ❑ **Pain prevents me from sitting for more than 1/2 hour.**
- ❑ **Pain prevents me from sitting for more than 10 minutes.**
- ❑ **Pain prevents me from sitting at all.**

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 me extra pain.**
- ❑ **Pain prevents me from standing for more than 1 hour.**
- ❑ **Pain prevents me from standing more than 1/2 hour.**
- ❑ **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 sleep well but only when taking medication.**
- ❑ **Even when I take medication, I sleep less than 6 hours.**
- ❑ **Even when I take medication, I sleep less than 4 hours.**
- ❑ **Even when I take medication, I sleep less than 2 hours.**
- ❑ **Pain prevents me from sleeping at all.**

SECTION 8 - SOCIAL LIFE

- ❑ **Social life is normal and causes me no extra pain.**
- ❑ **Social life is normal, but increases the degree of pain.**
- ❑ **Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.**
- ❑ **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 - SEXUAL ACTIVITY

- ❑ **Sexual activity is normal and causes no extra pain.**
- ❑ **Sexual activity is normal, but causes some extra pain.**
- ❑ **Sexual activity is nearly normal, but is very painful.**
- ❑ **Sexual activity is severely restricted by pain.**
- ❑ **Sexual activity is nearly absent because of pain.**
- ❑ **Pain prevents any sexual activity at all.**

SECTION 10 – 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 restricts me to journeys of less than 1 hour.**
- ❑ **Pain restricts me to necessary journeys under ½ hr.**
- ❑ **Pain prevents traveling except to the doctor/hospital.**

PERCENTAGE DISABILITY:_____%

Notice of Privacy Practices

Effective date: May 4, 2009

Vibrance Chiropractic & Wellness Center, LTD

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully. The privacy of your health information is important to us.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Vibrance Chiropractic & Wellness Center, 1301 Pyott Rd Ste 203, Lake In The Hills, IL 60156, Phone: 847-658-6066.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.
1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and

business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to authorized family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Vibrance Chiropractic & Wellness Center, LTD** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Vibrance Chiropractic & Wellness Center, LTD**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including

psychotherapy notes. You must submit your request in writing to **Vibrance Chiropractic & Wellness Center, LTD** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Vibrance Chiropractic & Wellness Center, LTD**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Vibrance Chiropractic & Wellness Center, LTD.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Vibrance Chiropractic & Wellness Center, LTD**.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Vibrance Chiropractic & Wellness Center, LTD**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Vibrance Chiropractic & Wellness Center, LTD at 847-658-6066**.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____Patient ID #:_____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of **Vibrance Chiropractic & Wellness Center, LTD**.

Signature: _____Date:_____

Print Name: _____

Relationship to Patient (if other than self): _____