MOUNTAIN CHIROPRACTIC, PC
1933 E. Main Street
Cortez, Colorado 81321

Today's Date: _____

PLEASE PRINT

Name First: _____ Middle Initial: ___ Last : _____ SS#: _____
Mailing Address: _____ Physical Address: _____
City. State, Zip Code _____ (If different) _____
Email address: _____
Birth Date: ___/___/_____ Age: ___ Sex (circle): M F Currently Pregnant (Circle): Yes No
Home Phone #: _____ Work Phone #: _____ Mobile #: _____
Name of Business/Employer: _____ Type of Work/Duties: _____
Name of Spouse: _____ (Circle One) Married Single Divorced Widowed Separated
Number of Children: _____
Emergency contact (name & number): _____
Who referred you to our office?

How will you be paying your bill today? (Circle One)
CASH CHECK CREDIT CARD WORKMAN'S COMPENSATION AUTO ACCIDENT

Health Insurance Company: _____ **Policy #:** _____
(We will need a copy of your insurance card)

Indicate where your symptoms are worse, using a scale 0-10 with 1 being mild and 10 being the worst

STRUCTURAL (Rate using numbers 0 – 10 with 1 being mild and 10 being the ,most severe) if you have had significant problems in any of these areas circle the number.

_____ Headache
_____ Jaw Pain
_____ Dizziness
_____ Neck Pain
_____ Upper Back Pain (between shoulders)
Radiation of neck/upper-back pain/numbness and/or tingling to:
_____ Upper Arm ___ Rt ___ Lt
_____ Elbow Pain ___ Rt ___ Lt
_____ Hands ___ Rt ___ Lt
_____ Mid Back Pain
_____ Rib Pain
_____ Shoulder Socket Pain ___ Rt ___ Lt
_____ Elbow Pain
_____ Wrist or Hand Pain ___ Rt ___ Lt

_____ Low Back Pain
Radiation of pain, numbness, or tingling from the low back to the:
_____ Hip ___ Rt ___ Lt
_____ Upper Leg ___ Rt ___ Lt
_____ Lower Leg ___ Rt ___ Lt
_____ Foot ___ Rt ___ Lt
_____ Hip Socket Pain ___ Rt ___ Lt
_____ Knee Pain ___ Rt ___ Lt
_____ Ankle Pain ___ Rt ___ Lt
_____ Foot Pain ___ Rt ___ Lt

CURRENT HEALTH CONDITION (Please fill out as completely as possible):
Main health complaint that brought you to this office: _____
Other doctors seen for this condition (circle one): Yes No Names if yes: _____
List date this condition began (or # of days, weeks, months, or years since onset) _____
Brief history of significant injury (year and type of injury) _____ None _____
_____
_____
_____
_____

Previous chiropractic care? Yes No Have you been treated in this office before? Yes No
Chiropractor's name and approximate date of last visit:_____

Height: _____feet ____inches Your weight:_____lbs.
Rate your overall Health: ___excellent ___very good ___good ____fair ___poor
Regular exercise you perform: ___strenuous ___moderate ___light ___none

Use Capital Letter to indicate if Mother (M), Father (F), Brother (B), and/or Sister (S) has had:
_____ rheumatoid arthritis, _____diabetes, _____cancer, ____lupus, _____Amyotrophic Lateral Sclerosis, ____heart problems. Any other significant chronic or serious disease? Please List which family member and disease : _____

YOUR CONDITIONS OR ILLNESSES
CIRCLE the condition you **HAVE NOW** and/or **CHECK** if you HAVE HAD IN THE PAST:
Chronic Sinusitis__past High Blood Pressure__past Heart Attack__past Chest Pains__past Stroke__past Angina__past Kidney Stones__past Kidney Disorders__past Bladder Infection__now__past Painful Urination__past Loss of bladder control__past Prostate problems__past Abnormal weight change__past Loss of appetite__past Abdominal pain_past Ulcer_past Hepatitis_past Liver/Gall bladder problems_past General fatigue__past Muscular un coordination__past Visual disturbances_ past Dizziness_past Diabetes_past Excessive thirst_past Frequent Urination_past Smoking/tobacco use_past Drugs/Alcohol dependency_past Allergies_past Depression_past SLE_past Epilepsy_past Dermatitis_past HIV/AIDS_past Birth control_past

Bone Fractures (list and date):_____
_____
List of Medications you now take:_____
_____
List of Supplements you now take:_____
_____
List and date any Hospitalizations and or Surgeries:_____
_____
Is there anything else that might affect your health that you think the doctor should know about?_____
_____

***Patient Signature:**_____
Parent or Guardian Signature:_____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. WE DO NOT EXTEND CREDIT.
We charge 8% interest in addition to a $10.00 billing fee per month on balance due for each month the account is delinquent. Patient is responsible for any attorney or collection agency fees accrued during any collection of delinquent accounts. Any billing of insurance companies (or any third party) is done as a courtesy for our patients, the patient (or legal guardian) is ultimately responsible for full payment of services rendered.

FOR PATIENTS UNDER AGE 18 (Please fill in the information concerning responsible party)
Name of Parent/Guardian:_____Place of Employment_____
Phone#:_____Work#:_____Mobile#:_____
Drivers License#:_____State:_____SS#:_____
Address: **City:** **State:** **Zip Code:**

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EHR Certification – Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: *(To be entered in EZnotes through "Edit Patient Info")*

Name: (Print clearly) _____ **Today's Date:** _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell

Phone Call: ☐ Text Message: ☐

E-Mail: _____

Mailing Address: _____

_____

_____

OFFICE USE ONLY

Vitals: *In EZnotes, complete by*

1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ **Height:** _____ Weight: _____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

Timely access: *In EZnotes, complete by*

1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*"

☐ Completed?

Medications*: In EZnotes, complete by*

1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

☐ Completed?

Entered into EZnotes by (name): _____ Date & Time: _____

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OFFICE POLICIES & PROCEDURES AGREEMENT
MOUNTAIN CHIROPRACTIC, P.C. 1933 E. Main Street, Cortez, CO 81321 (900) 565-4800

FINANCIAL ARRANGEMENTS AND POLICIES

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged 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. I also understand that on unpaid balances I will keep in regular contact with this office regarding the status of 3rd party reimbursement and/or settlement of this claim.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for products purchased and services provided by our office. For your convenience our office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefits. Your insurance company make the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of care, times arise where insurance companies do not reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral if required but not provided at the time of your visit full payment is expected at the time of service.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of the service rendered. Bills that are delinquent more than sixty (60) days or failure to comply with the above described terms of communication regarding 3rd party payment will be transferred to our collection process. Patients will be responsible for collection and attorney's fees for all such disputed. If there are legitimate problems, please discuss them prior to the sixty days so we may find a workable solution.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that as in the practice of medicine in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to fracture, disc injuries, strokes, dislocations, strains and worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPPA- I have been given a copy of the Mountain Chiropractic, P.C. Patient Privacy Statement.

RECORDS RELEASE AUTHORIZATION

I hereby grant permission for Mountain Chiropractic, P.C. To release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist whom I am currently or have previously been under their care. In accordance with all stated above, I hereby understand and agree to the above stated office policies.

PRINT Patient's Name: _____ Date:_____
SIGNATURE of Patient: _____ Date:_____
SIGNATURE of Parent or Guardian:_____ Date:_____
WITNESS: _____ Date:_____

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Mountain Chiropractic, P.C.
1944 E. Main Street
Cortez, CO 81321
(970) 565-4800

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use of disclosure of my protected health information by Mountain Chiropractic, P.C. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mountain Chiropractic, P.C.

I under that diagnosis or treatment of me by Mountain Chiropractic, P.C. Is not required to agree to the restrictions that I may request. However, if Mountain Chiropractic, P.C. Agrees to a restriction that I request. The restriction is binding on me and Mountain Chiropractic, P.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Mountain Chiropractic, P.C. Or I have taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review Mountain Chiropractic, P.C.'s Notice of Privacy Practices prior to signing this document.

Mountain Chiropractic, P.C.'s Notice of Privacy practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment payment of my bills or in the performance of health care operations of the Mountain Chiropractic, P.C.

The Notice of Privacy Practices for Mountain Chiropractic, P.C. Is provided at 1933 E. Main Street, Cortez, CO 81321.

The Notice of privacy practices also describes my rights and the duties of Mountain Chiropractic, P.C. With respect to my protected health information.

Mountain Chiropractic, P.C. Reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or personal Representative

_____
Description of Personal Representative's Authority

_____
Date

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MOUNTAIN CHIROPRACTIC, P.C.
MICHAEL R. TREINEN, D.C.

Effective September 23, 2013 the Federal government requires enactment of new HIPAA regulations to which all medical providers must comply, or be faced with prosecution and penalties ranging from $100 to $50,000 per violation, and fines can reach up to $1,500,000 per year.

All new patients must review and sign the ***"Notice of Privacy Practices"*** in the following pages.

1933 E. Main Street, Cortez, Colorado 81321
(907) 565-4800, Fax (970)565-0821

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MOUNTAIN CHIROPRACTIC, P.C.

MICHAEL R. TREINEN, D.C. 1933 E. Main Street • Cortez, Colorado 81321
(970) 565-4800 • FAX (970) 565-0821

Notice of Privacy Practices

Effective September 22, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

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OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

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If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

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authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

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Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military

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Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Michael R Treinen, DC
Mountain Chiropractic, PC
1933 East Main Street, Cortez, Colorado 81321
(970) 565-4800

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____