WATKINS TOTAL HEALTHCARE

961 Green Street, NE | Gainesville, GA 30501
Phone: 770-534-0656 | Fax: 770-534-9553

Email this completed form to WatkinsTotalHealth@gmail.com or bring it to your appointment.

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

May we leave a voicemail/message? YES☐ NO☐ Cell phone Carrier: _____

Email Address: _____

Sex: MALE☐ FEMALE☐ Date of Birth: _____ SS#: _____

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Separated☐ Other☐

Employer: _____ Occupation: _____

May we call you at work? YES☐ NO☐ Work number: _____

Who referred you to our practice? _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: (Home) _____ (cell) _____ (Work) _____

ACCIDENT INFORMATION

Is this visit due to an accident? YES☐ NO☐ Type of accident? AUTO☐ WORK☐ OTHER☐

Has it been reported? YES☐ NO☐ Whom was it reported to? _____

Patient Name _____ **DOB** _____

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RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
Last First Middle

Address (if different from above): _____

Phone: (Home) (Cell) (Work)

Responsible Party's Employer: _____

INSURANCE INFORMATION

We cannot file your insurance if this section is left uncompleted and the bill will be sent to you.

PLEASE PROVIDE THIS OFFICE A COPY OF YOUR INSURANCE CARD(S)

Do you have health insurance? YES☐ NO☐ Name of Carrier: _____

Do you have a secondary insurance? YES☐ NO☐ Name of Carrier: _____

Name of Policy Holder: _____ SS#: _____

Relationship to patient: _____ DOB: _____ Phone: _____

ID #_____ Group # _____

Member service phone number: _____

Patient Name _____ **DOB** _____

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Patient Name: _____ Date of Birth:_____

Primary Care Physician: _____ Phone #: _____

Are you currently under drug and/or medical care? YES__ NO__ Explain: _____

Date of last Physical exam: _____ Last labs: _____

Do you see a specialist: (May we have their name and specialty?)

Allergies: (list all allergies, types of reaction, and year of reaction)

Medications: (list all current medications you currently take, include vitamins, herbal supplements, and any over the counter medicines)

Name of Medication	Dose	Frequency Taken	Diagnosis/Reason

Surgeries/Hospitalizations: (please list all)

Year	Surgery	Overnight stay at hospital	Name of Hospital

Patient Name _____ **DOB** _____

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Please complete the following items that apply to you:

Caffeine per day: (this includes coffee, teas, and soda) None☐ 1-3 cups☐ 3-6 cups☐ 6+ cups☐

Tobacco Use: Never☐ Former smoker☐ Current smoker _____ packs/day☐

Alcohol: NONE☐ Casual☐ Moderate☐ Heavy☐ Beer☐ Wine☐

Drug use: YES☐ NO☐

Exercise: NONE☐ Daily☐ Weekly☐ Walks☐ Runs☐ Swims☐

Does your work activities mostly involve: Sitting☐ Standing☐ Light Labor☐ Heavy Labor☐

Do you sleep on your: Back☐ Side☐ Stomach☐

Do you use a cervical pillow? YES☐ NO☐

Which is your dominate hand? Right☐ Left☐

Patient Name _____ **DOB** _____

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Please indicate if you are currently experiencing any of the following conditions:

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Leg/Knee Pain
- ☐ Headaches
- ☐ Dizziness
- ☐ Asthma
- ☐ Pins/Needles in Arm
- ☐ Pins/Needles in Legs
- ☐ Fatigue
- ☐ Sleeping Difficulties
- ☐ Loss of Smell
- ☐ Allergies
- ☐ Blurred Vision
- ☐ Light Bothers Eyes
- ☐ Depression
- ☐ Nervousness
- ☐ Tension
- ☐ Cold Sweats
- ☐ Stomach Problems
- ☐ Night Pain
- ☐ Sudden Weight Loss
- ☐ Loss of Taste
- ☐ Loss of Memory
- ☐ Jaw Problems
- ☐ Constipation
- ☐ Shortness of Breath
- ☐ Bowel/Bladder Changes
- ☐ Nausea
- ☐ Cold Feet
- ☐ Chest Pain
- ☐ Fever
- ☐ Fainting

Please indicate if you have ever had any of the following:

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Other_____
- ☐ Suicide Attempts
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough

Briefly describe any medical illness you are being treated for:

Family History:
Is there a family history of the following conditions? (Indicate parent, grandparent, or sibling)

Cancer _____ Hypertension _____

Diabetes _____ Kidney Disease _____

Heart Disease _____ Stroke _____

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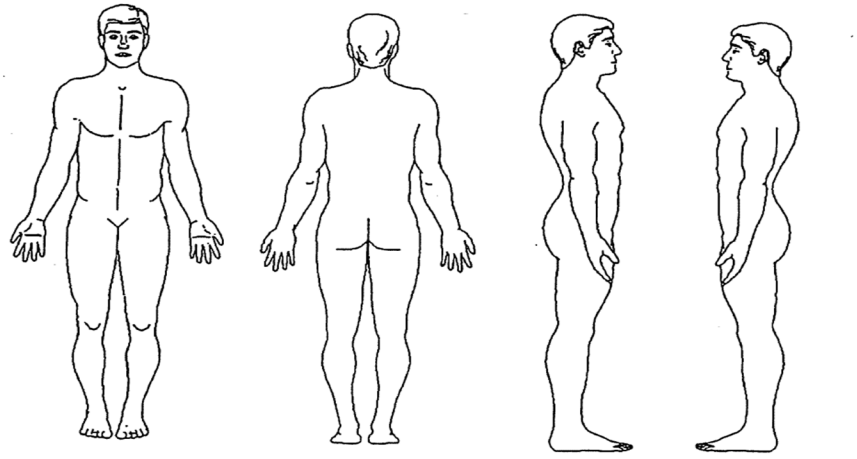
CURRENT SYMPTOM(s)

Patient Name: Chart Number:

Reason for visit:

Please use the letter(s) below to mark the drawing(s) with the location and type of sensations you are experiencing. Please mark all symptoms thoroughly so we can better assist you.

P = Pain
D = Dull
N = Numb
B = Burning
T = Tingling
SH = Shooting
TH = Throbbing
O = Other
M = Muscle Spasm



PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF 0-10

(0 being no pain, 10 being the worst possible pain)

Currently: At Its Worst:

When did you first notice the symptoms?

Did anything cause the pain/symptoms?

Is the pain: Constant: _____ Intermittent (Come and Go): _____

Is it getting progressively worse? No: ☐ Yes: ☐

Pain Type? Tight: ☐ Stiff: ☐ Ache: ☐ Sharp: ☐ Shooting: ☐

Throbbing: ☐ Burning: ☐ Dull: ☐ Numb: ☐ Tingling: ☐ Other: ☐

Does anything make it worse?

Does anything make it better?

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Does it radiate? No: ☐ Yes: ☐

Where does it radiate? Right Arm: ☐ Left Arm: ☐ Right Leg: ☐ Left Leg: ☐

Do you experience pain at a particular time of day? No: ☐ Yes (explain): _____

Do you experience night pain? No: ☐ Yes (explain): _____

Does it interfere with your: Work: ☐ Sleep: ☐ Daily Routine: ☐ Recreational Activities: ☐

What activities do you enjoy, but do poorly or not at all because of the pain?

Painful movements: Sitting: ☐ Standing: ☐ Walking: ☐ Bending: ☐ Lying Down: ☐

What have you done to treat the pain before today?

Patient Signature (X): Date:

Parent/Guardian Signature (X): Date:

Patient Name _____ **DOB** _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

For any **YES** answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? No ☐ Yes ☐
   Comment:
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? No ☐ Yes ☐
   Comment:
3. Do your hands or arms fall asleep regularly? No ☐ Yes ☐
   Comment:
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? No ☐ Yes ☐
   Comment:
5. Do you suffer from a loss of handgrip strength? No ☐ Yes ☐
   Comment:
6. Do you suffer from back pain with pain in your buttocks, legs or feet? No ☐ Yes ☐
   Comment:
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? No ☐ Yes ☐
   Comment:
8. Do your legs or feet fall asleep regularly? No ☐ Yes ☐
   Comment:
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? No ☐ Yes ☐
   Comment:
10. Do you suffer from cold hands or feet? No ☐ Yes ☐
    Comment:
11. Do you suffer from headaches, dizziness or memory loss? No ☐ Yes ☐
    Comment:
12. Do you have difficulty maintaining your balance? No ☐ Yes ☐
    Comment:
13. Do you have vertigo or blurred vision? No ☐ Yes ☐
    Comment:
14. Do you suffer from a reduced hearing capacity? No ☐ Yes ☐
    Comment:
15. Do you suffer from ringing in your ears? No ☐ Yes ☐
    Comment:
16. Do you have bladder or bowel control problems on a regular basis? No ☐ Yes ☐
    Comment:

Neck Index

Patient Name: _____ **Date of Birth:** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain comes and goes and is moderate
- ☐ 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

Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Reading

- ☐ I can read as much as I want with no neck pain
- ☐ I can read as much as I want with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I cannot read as much as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all because of neck pain

Concentration

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

Work

- ☐ I can do as much work as I want
- ☐ I can only do my usual work but no more
- ☐ I can only do most of my usual work but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

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 I manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I was with difficulty and stay in bed

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights.
- ☐ I cannot lift of carry anything at all

Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I cannot drive my car as long as I want because of moderate neck pain
- ☐ I can hardly drive at all because of severe neck pain
- ☐ I cannot drive my car at all because of neck pain

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain
- ☐ I am able to engage in all my usual recreation activities with some neck pain
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain
- ☐ I can hardly do any recreation activities because of neck pain
- ☐ I cannot do any recreation activities at all

Headaches

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

Back Index

Patient Name: _____ **Date of Birth:** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild
- ☐ The pain is mild and does not vary much
- ☐ The pain comes and goes and is moderate
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is very severe
- ☐ The pain is very severe and does not vary much

Sleeping

- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ Because of pain my normal sleep is reduced by less than 25%
- ☐ Because of pain my normal sleep is reduced by less than 50%
- ☐ Because of pain my normal sleep is reduced by less than 75%
- ☐ Pain prevents me from sleeping at all

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 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Standing

- ☐ I can stand as long as I want without pain
- ☐ I have some pain while standing but it does not increase with time
- ☐ I cannot stand for longer than 1 hour without increasing pain
- ☐ I cannot stand for longer than 1/2 hour without increasing pain
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases pain immediately

Walking

- ☐ I have no pain while walking
- ☐ I have some pain while walking but it doesn't increase with distance
- ☐ I cannot walk more than 1 mile without increasing pain
- ☐ I cannot walk more than 1/2 mile without increasing pain
- ☐ I cannot walk more than 1/4 mile without increasing pain
- ☐ I cannot walk at all without increasing pain

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it cause some pain
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it
- ☐ Because of the pain I am unable to do some washing and dressing without help
- ☐ Because of the pain I am unable to do any washing and dressing without help

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. table)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights

Traveling

- ☐ I get no pain while traveling
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel
- ☐ Pain restricts all forms of travel except that done while lying down
- ☐ Pain restricts all forms of travel

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 of my social life apart from limiting my more energetic interests (e.g. dancing)
- ☐ Pain has restricted my social life and I do not of out very often
- ☐ Pain has restricted my social lift to my home
- ☐ I have hardly any social life because of the pain

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
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Patient Name _____ **DOB** _____

Notice of Patient Privacy Policy

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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Jeanne Hanlin.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.watkinstotalhealthcare.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. Open treatment areas will be utilized for part of your care, however, private rooms are available upon request.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *disclosures of psychotherapy notes*
- *uses and disclosures of Protected Health Information for marketing purposes;*
- *disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

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Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- **You have the right to considerate and respectful service.**

- **You have the right to obtain services without regard to race, creed, national origin, sex, age, disability, diagnosis, or religious affiliation.**

- **You have a right to make informed decisions about your care.**

- **You have the right to reasonable continuity of care and services.**

Patient Name _____ **DOB** _____

- **You have the right to voice grievances without fear of termination of services or other reprisal in the service process.**

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.**

C. Patient Responsibilities

- **TENS Units and LSO Braces:**
  You should promptly notify Watkins Total Healthcare of any failure or malfunction of the device. Notify the office of discontinuance of use. Except where contrary to federal or state law, you, the patient, is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

- **Changes:**
  You, the patient, should promptly notify Watkins Total Healthcare of any changes to your address, phone number, insurance information, or any changes concerning your physician.

D. Complaints

It is always our policy to provide the highest quality of service and products to you, our patient. However, if you have a complaint we encourage you to put it in writing or ask to meet with our Compliance Officer, Diane Brown or our Director of Operations Jeanne Hanlin. We will work with you to resolve the issue. If in the event your complaint is not resolved, you can call the Compliance Team for help in getting it resolved. You may also contact the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Diane Brown you may contact our Privacy Officer, or any staff member, including Dr. Watkins at the following phone number 770-534-0656 or our website, at www.watkinstotalhealthcare.com for further information about the complaint process.

This notice was published and becomes effective on January 6, 2015.