Workers Compensation Questionnaire

1. What was the date of the injury?_____

2. What time did the injury occur?_____

3. What is the name of your employer?_____

4. What is the street address of your employer? _____

5. What is the City, State, and Zip of your employer? _____

6. What is the name of your attorney? _____

7. What is the street address of your employer? _____

8. What is the City, State, and Zip of your attorney? _____

9. Please describe your incident in a few sentences: _____

_____

_____

_____

10. Did you report the incident to your supervisor? _____

11. What is your Supervisor's name? _____

12. Did your employer send you to a doctor? If yes, please provide the doctor's name

_____

13. Did you go to a doctor on your own? If yes, please provide the doctor's name

_____

14. Are there any other problems that affect your employment?

_____

15. Does your job cause you to favor one side of your body? _____

16. Before the injury, were you capable of performing equal work with others your age?

_____

18. Have you injured this area before? -yes - no

Walters Chiropractic PC
121 West King Street / 735 Harrisburg Pike
East Berlin PA 17316 / Dillsburg PA 17019
717-259-8056 / 717-432-7780

Patient Name_____Date_____

Birthdate_____Sex: Male / Female Single / Married / Other_____

Address_____

_____

Home Phone_____Mobile Phone_____

Email Address_____

Employer Name_____

Employer Address_____

_____

Employer Phone_____Occupation_____

Insurance Company_____

Name of Insured_____

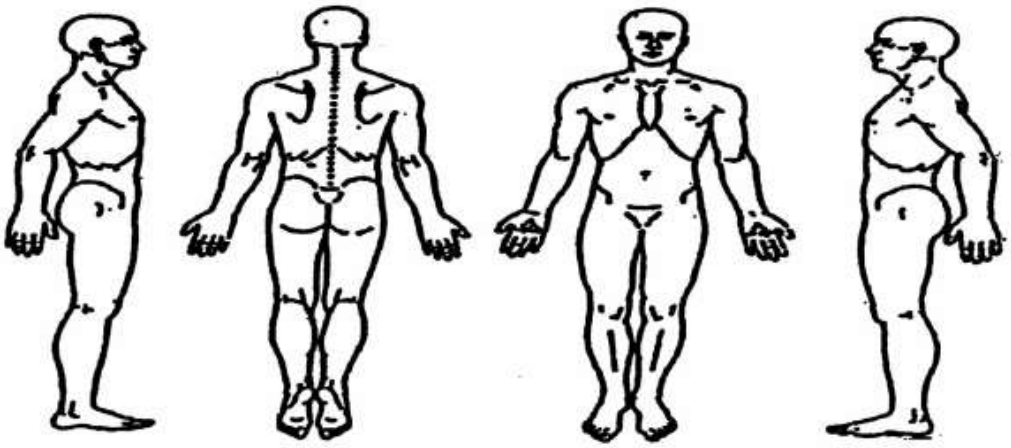
Relationship to Insured_____Insured Birthdate_____

PATIENT INTAKE FORM

.

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Not Changing □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ Slightly □ Moderately Substantially □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor. Date of Last visit?_____ □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?_____
____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem? **13b.What relieves your problem?**

_____ _____

14. What concerns you the most about your problem? **14b. What does it prevent you from doing?**

_____ _____

15. What is your Occupation? _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain				
□	□ Lower Leg Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

.

19. List all of the supplements you are currently taking:
_____

20. List all surgical procedures you have had, or if you have been hospitalized and why:
_____

21. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Driving vehicle:**	□ Most of the day	□ Half of the day	□ A little of the day
□Performs Manual Labor	□ Reads a lot	□ Travels frequently	

22. What activities do you do outside of work?_____

23. Have you ever been to a chiropractor? □ No □ Yes
if yes, how long ago?_____

24. Have you had significant past trauma? □ No □ Yes explain_____

25. Anything else pertinent to your visit today?_____
_____

Patient Signature_____ **Date**_____

EHR Certification
PATIENT DEMOGRAPHICS:

Today's Date_____

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

Ethnicity: (circle one)

Hispanic or Latino	Not Hispanic or Latino

Race: (circle one)

White	American Indian/Native	Asian
Black	Native Hawaiian/Pacific Islander	

Preferred Language (circle one)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Japanese	Tagalog	Other

Phone Number:_____Is this # for: Home Work Cell
Email Address:_____

What is your preferred Method of Contact? (Circle all that apply)

Phone Call	Text	Email

For confidential correspondence, please create a Secret Question, i.e. Mother's maiden name.
Secret Question:_____
Secret Answer:_____

Have you had a flu shot this season? Yes or No_____
(approximate date)

Smoking Status: (Circle one)

Daily Smoker	Smokes some days	Former Smoker	Never Smoked

If you smoke, how many cigarettes per day?_____

Family History (indicate Mother, Father, Brother, Sister, Son , Daughter):
Heart Disease_____ Diabetes_____ Cancer_____
Lupus_____ Rheumatoid Arthritis_____ ALS_____

Have you ever been diagnosed with the folowing? (circle all that apply)

Asthma	Diabetes	Hypertension (High Blood Pressure)

Prescribed Medications: If not taking an medications check here_____

Medication Name	# of Refills issued:	Quantity of Pills	Strenth (mg)	MD's Instructions ie. 1 per day

Medication Allergies: If no allergies check here____

Name of Drug	Symptom	Severity (mild, moderate, Severe, Fatal)

OFFICE USE ONLY
Blood
Pressure _____/_____ Pulse_____ Height_____ Weight_____

Timely Access: Completed (initial)_____
Medications: Entered by (name)_____ Date and Time_____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE 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 -DAY SITUATION.

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

- ❑ 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 – WORK

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

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 without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – 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 can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] % score = _____

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Walters Chiropractic PC
121 W King St.
East Berlin PA, 17316 - 717-259-8056

Name: _____ **Date**_____

The Revised Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much you low back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE THAT MOST APPLIES TO YOU TODAY.

Section 1 – 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 severe.
- ❑ The pain is severe and does not vary much.

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ 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 causes 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.

Section 3 - 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. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

Section 4 – Walking

- ❑ I have no pain on walking.
- ❑ I have some pain on walking, but it does not increase with distance.
- ❑ I cannot walk more than one 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.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than1/2 hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ I avoid sitting because it increases pain immediately.

Section 6 – Standing

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one 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 the pain immediately.

Section 7 – 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 night's sleep is reduced by less than 1/4.
- ❑ Because of pain my normal night's sleep is reduced by less than 1/2.
- ❑ Because of pain my normal night's sleep is reduced by less than 3/4.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social life

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

Section 9 – Travel

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling, but it does not compel me to see alternative forms of travel.
- ❑ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

Section 10 – Changing degree of pain

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

OFFICE USE: Score_____ _____%Disability

WALTERS CHIROPRACTIC PC
121 West King St
East Berlin, PA 17316

ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Benefits/Financial Responsibility
The undersigned hereby authorizes Dr. Shannon Walters to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment if any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

Designation of Authorized Representative
The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974(ERISA) as provided in 29 CFR 2560-503-1(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents, claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

Authorization for Release of Information
The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment. The undersigned hereby authorizes my Employer to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

Revocation and Acknowledgement
A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefits claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to this Provider; however, the undersigned understands that all actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Important Information for our Patients Regarding Exams and Re-Exams

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal law and the American Medical Association. These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules and of uncovered services.

Examples of services not covered may include, but not limited to:
Examinations and Re-Examination: Both of which are periodically necessary to justify the medical necessity of your chiropractic care.
Spinal Manipulation
Physical Medicine: such as ultrasound, muscle stimulation and massage therapy.
Supplies: such as pillows, biofreeze, orthotics, supports, supplements, etc.

Our Doctor cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment from your Insurance Company!

While we regret that your Insurance carrier may not pay for more Exams and Re Exams, it is required to prove medical necessity of all care performed in our office. If at any time your Insurance Company denies payment, you will be responsible for the payment due.

Our able, experienced business office staff will be happy to assist you with any questions. Providing you with high quality healthcare remains our first priority. We thank you for choosing us to assist you with your healthcare needs.

Patient Signature:_____ Date:_____

Permission to Release Medical Information to Another Individual

On occasion, we have had family members call regarding appointments, account balances, status of treatment plan, etc. According to the Health Information Portability and Accountability Act (HIPAA), we are unable to release any protected health information to anyone without a written authorization. **THIS AUTHORIZATION IS VALID UNTIL A NEW RELEASE FORM IS COMPLETED**

If you wish to authorize a person to receive any medical information on your behalf, please complete the form below.

Print Patient's Full Name_____**Date of Birth**:_____

Effective Date of Authorization (today's date):_____

At my request, I give Walters Chiropractic permission to release and discuss protected health information with the following person(s):

Name:_____Relationship:_____

Date of Birth:_____Phone Number:_____

Name:_____Relationship:_____

Date of Birth:_____Phone Number:_____

I give Walters Chiropractic entities permission to leave any protected health information on an answering machine or voicemail.

☐ YES ☐ NO

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES AND PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Walters Chiropractic Notice of Privacy Practices for protected health information.

I hereby request and consent to the performance of chiropractic adjustments, physical medicine, x-rays and exercises. My treatment in this office may include any of the above mentioned treatments. Though chiropractic treatment is usually beneficial, I understand and have been informed that it is not an exact science and no guarantee has been made to me. I have had the opportunity to discuss with the doctor and/or staff the benefits of an adjustment and other treatment performed in the office. I have had the opportunity to ask questions about my concerns and authorize treatment.

Print Patient's Name:_____Date:_____

Patient Signature:_____

HIPAA Notice of Privacy Practices

WALTERS CHIROPRACTIC PC
121 WEST KING STREET/735 HARRISBURG PIKE
EAST BERLIN PA 17316/DILLSBURG PA 17019
717-259-8056/717-432-7780

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students 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 physician. We may also call you by name in the waiting room when your physician 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

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

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 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 state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – 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.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER	Phone	email
MELISA BUSBEY	717-259-8056	walterschiro@wchiro.comcastbiz.net

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Form provided by: HCSI – 801947-0183 – http://www.hcsiinc.com