



Name: \_\_\_\_\_ Pronoun: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ cell/home Appointment reminders? **TEXT or EMAIL?**

Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Spouse/Significant Other's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Sex: *M F* Marital Status: *M S D W* Your Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact and Phone Number: \_\_\_\_\_

Have you ever received Chiropractic Care?  Yes  No If yes, when? \_\_\_\_\_

Auto Insurance Co: \_\_\_\_\_ Agent/Adjuster Name: \_\_\_\_\_

Agent/Adjuster Phone #: \_\_\_\_\_ Agent/Adjuster Email: \_\_\_\_\_

Policy Holder's Name (if other than self): \_\_\_\_\_ Policy #: \_\_\_\_\_

**How Did You Hear About Us?** (who may we thank?)

Referred by:  Family/Friend: \_\_\_\_\_  Google  Yelp  Social Media

Health Professional: \_\_\_\_\_  Attorney: \_\_\_\_\_

**Information About Your Attorney:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Information About Your Accident:**

Date: \_\_\_\_\_ Time of day: \_\_\_\_\_ Number of people in your vehicle: \_\_\_\_\_

**Were you:**  Driver  Front Passenger  Left Rear Passenger  Middle Rear Passenger

Right Rear Passenger  Wearing Seatbelt  Wearing Glasses/Hat

**Where were you struck from:**  Behind  Front  Left Side  Right Side

**Did you brace for the impact:**  Yes  No

**Did the airbag deploy:**  Yes  No

**Headrest Position:**  Even with Top of Head  Even with Bottom of Head  Middle of Neck



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Email:renobacktohealth@gmail.com

Did you strike anything in car:  Wheel  Windshield  Arm Rest  Dashboard  Side Door  Airbag

Where were your hands:  Both on Wheel  One Hand on Wheel

What direction were you looking:  Front  To the Left  To the Right  Rearview  Lap

Approximate speed of your car: \_\_\_\_\_ Approximate speed of the other car: \_\_\_\_\_

How was the visibility on the road:  Good  Fair  Poor

How was the weather:  Clear  Raining  Windy  Foggy  Snowy

Did you lose consciousness:  Yes  No If yes, approximately how long? \_\_\_\_\_

Were police notified:  Yes  No If yes, is there a police report? \_\_\_\_\_

Were there any witnesses:  Yes  No Names: \_\_\_\_\_

Estimated damage to vehicle: \_\_\_\_\_ Who provided the estimate: \_\_\_\_\_

In your own words, please describe the accident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please draw a picture of the motor vehicle accident:

Were you taken to a hospital after your current accident?  Yes  No

What hospital: \_\_\_\_\_

Name(s) of treating physician(s): \_\_\_\_\_

Was imaging performed (x-ray, CT, MRI)?: \_\_\_\_\_

List all the health professional(s) seen since your accident: \_\_\_\_\_

**Information About Your Symptoms:**

Please describe how you felt:

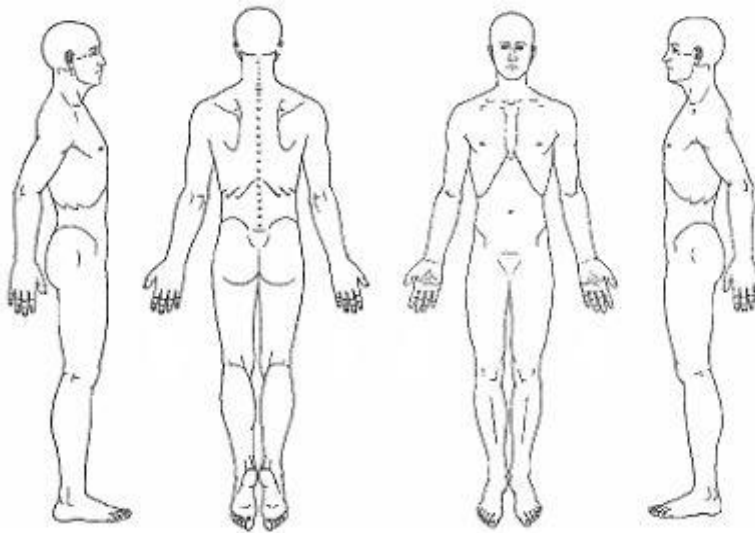
During the Accident: \_\_\_\_\_ Immediately After: \_\_\_\_\_

Later that Day: \_\_\_\_\_ The Next Day: \_\_\_\_\_

What are your **PRESENT** complaints and symptoms?

\_\_\_\_\_

Since the injury occurred, are your symptoms:  Improving  Getting Worse  Same



Please check all symptoms you have noticed since the accident:

- |   |  |   |  |                                     |
|---|--|---|--|-------------------------------------|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> Face Flushed                | <input type="checkbox"/> Feet Cold  |
| <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Buzzing in Ears             | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff         | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Loss of Balance             | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Stomach Upset      | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Head is Heavy        | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Fatigue    |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Cold Sweats         | <input type="checkbox"/> Light Sensitive Eyes | <input type="checkbox"/> Loss of Smell               | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste        | <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Tension    |
| <input type="checkbox"/> Numbness (up. ext) | <input type="checkbox"/> Numbness (low. ext) | <input type="checkbox"/> Ears Ringing         | <input type="checkbox"/> Pins/Needles (arms or legs) |                                     |

Symptoms other than above: \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst; **what number** best describes your symptom most of the time (mark one):      1 2 3 4 5 6 7 8 9 10
- What **percentage of the time** you are awake do you experience the above symptom(s) at the above intensity (mark one):  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom(s) begin **immediately** or **gradually**? (mark one)
- Is it getting **better**, **worse** or the **same**? (mark one)



- **When/how** did the symptom(s) **begin**?

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- What are you having **problems** with? (mark all that apply):
  - seeing, hearing, reading, holding, walking, kneeling, lifting, sitting, sports, reclining, insomnia, loss of concentration, change in personality, tasting, bathing, typing, pinching, stooping, bending, pushing, driving, exercising, restful sleep, using the toilet, smelling, grooming, writing, standing, squatting, twisting, pulling, riding in car, loss of sexual drive, nervous, tactile feeling, eating, dressing, grasping, leaning, climbing, carrying, reaching, air travel, irritable, nothing,
  - other (please describe): \_\_\_\_\_

- What makes the symptom(s) **better**? (mark all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe):

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- Describe the **quality** of the symptom(s) (mark all that apply):
  - dull, sharp, achy, shooting, spasm, throbbing, burning, numbing, tingling
  - other (please describe): \_\_\_\_\_

- Does the symptom(s) **radiate** to another part of your body (mark one):      yes      no
  - if yes, where does the symptom radiate? \_\_\_\_\_

- Is the symptom(s) **worse** at certain times of the day or night? (mark all that apply)
  - No difference    Morning    Afternoon    Evening    Night    Other: \_\_\_\_\_

- Are you able to **sleep without** pain?                              yes      no
  - does it **wake** you?    yes      no
  - did you have trouble sleeping **before**?                              yes      no

- Have you received **other** treatment for this condition and episode prior to today's visit?

(NSAIDS, pain rx, muscle relaxers, trigger point injections, prolotherapy, surgery, massage, PT, chiropractic, etc.)

Do you notice any activity restrictions as a result of this accident?

Yes

No

If yes, please describe: \_\_\_\_\_

Did you have any physical complaints **before** the accident?

Yes

No

If yes, please describe: \_\_\_\_\_

Have you ever been involved in an accident before?

Yes

No

If yes, please describe (**include dates, types and injuries received**):

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**Past Health History:**

Have you had any of the following **pulmonary (lung-related)** issues?  None

Asthma	Emphysema	Other:
COPD	Other:	Other:

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?  None

Angina/chest pain	Heart disease/problems	Murmurs/valve disease
Congestive heart failure	Hypertension	Other:
Heart attacks/MIs	Irregular heartbeat	Other:

Have you had any of the following **neurological (nerve-related)** issues?  None

Headaches	Memory loss	Vertigo
Loss of smell/taste	Seizures	Visual changes/loss of vision
One-side weakness face/body	Strokes/TIA	Other:
One-side decreased feeling in face/body	Tremors	Other:

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?  None

Diabetes	Injectable steroid replacements	Other:
Endometriosis	Painful periods	Other:
Hormone replacement therapy	Thyroid disease	Other:

Have you had any of the following **renal (kidney-related)** issues or procedures?  None

Bladder infections	Hematuria (blood in urine)	Renal calculi/stones
Dialysis	Incontinence	Other:
Difficulty urinating	Kidney disease	Other:

Have you had any of the following **gastroenterological (stomach-related)** issues?  None

Bloody/black stools	Gastroesophageal reflux/heartburn	Ulcerative disease
Bowel incontinence	Hepatitis/liver disease	Pancreatic disease
Constipation	Hiatal hernia	Vomiting
Difficulty swallowing	Irritable bowel/colitis	Other:
Frequent abdominal pain	Nausea	Other:

Have you had any of the following **hematological (blood-related)** issues?  None

Abnormal bleeding/bruising	Hemophilia	Regular aspirin use
Anemia	HIV positive	Sickle-cell anemia
Anticoagulant therapy	Hypercoagulation/ DVT/blood clots	Other:
Enlarged lymph nodes	Regular anti-inflammatory use	Other:

Have you had any of the following **oncological (cancer-related)** issues?  None

Abnormal bleeding/bruising	Fever/chills/sweats/unexplained weight loss	Other:
Cancer:	Other:	Other:

Have you had any of the following **dermatological (skin-related)** issues?  None

Psoriatic disorders	Significant rashes	Other:
Significant burns	Skin grafts	Other:



Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?  None

Arthritis (unknown type)	Metal implants	Spinal surgery
Broken bones	Osteoarthritis	Other:
Gout	Rheumatoid arthritis	Other:
Joint surgery	Scoliosis	Other:

Have you had any of the following **psychological** issues?  None

Bipolar disorder	Psychiatric	Schizophrenia
Depression	Psychiatric hospitalizations	Other:
Homicidal ideations	Suicidal ideations	Other:

Is there anything else in your past medical history that you feel is important to your care here?

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**Surgeries:** (if applicable, write year in the adjacent box)  None

Abdominal Exploration		Hemorrhoid Surgery	
Abdominoplasty		Hernia Repair	
Abortion		Hip Replacement	
ACL Reconstruction		Hysterectomy	
Adenoid Removal		Kidney Transplant	
Angioplasty		Knee Arthroscopy	
Appendectomy		Knee Replacement	
Bunion Removal		LASIK	
Carotid Artery Surgery		Liposuction	
Cataract Surgery		Lumbar Spine Surgery	
Cervical Spine Surgery		Mastectomy	
Cholecystectomy		Prostate Removal	
Cosmetic Breast Surgery		Rotator Cuff Surgery	
C-Section		TMJ Surgery	
Facelift		Tonsillectomy	
Gastric Bypass		Vasectomy	
Heart Surgery		Other:	

**Previous Injury or Trauma:**

(falls, accidents, sports, etc.)

**Allergies:** (mark all that apply)  None

Acetaminophen	Fragrance	Pollen
Adhesive Tape	Ibuprofen	Soy
Barbiturates	Insulin	Sulfa
Bee/Yellow Jacket Stings	Iodine	Tobacco Smoke
Dairy	Latex	Wheat/Gluten
Dust Mites	Mold	Other:
Eggs	Nuts	Other:
Fish/Shellfish/Seafood	Pet Dander	Other:



**Family Health History:** (mark all that apply)  None

Cancer	Heart disease	Other:
Cardiac disease below age 40	Neurological diseases	Other:
Diabetes	Psychiatric disease	Other:
Headaches	Strokes	Adopted/Unknown

**Medications:** (mark if currently taking)  None

Advil/NSAIDS	Gabapentin
Ambien	Statin Medications
Aspirin	Tylenol
Blood Pressure Medications	Vicodin/Other Pain Medication
Daily Vitamins/Prenatal Vitamins	Other:
Diabetes Medications	Other:
Muscle Relaxers	Other:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Social and Occupational History:**

A. Job description: \_\_\_\_\_  
(what level of satisfaction do you have in your job?)

B. Work schedule: \_\_\_\_\_

C. Recreational activities: \_\_\_\_\_

**D. Lifestyle:**

Level of Exercise: \_\_\_\_\_

Alcohol Use: \_\_\_\_\_

Tobacco/Drug Use: \_\_\_\_\_

**Information About Your Occupation:**

Have you lost time from work due to this accident?  Yes  No

Type of employment: \_\_\_\_\_

Last day you worked: \_\_\_\_\_

Present Salary: \_\_\_\_\_

Are you being compensated for time lost from work?  Yes  No

If yes, type of compensation you are receiving: \_\_\_\_\_

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Signature of Patient (guardian signature if patient is under 18)

\_\_\_\_\_  
Date

NECK BOURNEMOUTH QUESTIONNAIRE (Bolton JE, Humphreys BK: The Bournemouth Questionnaire)

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

**1. Over the past week, on average, how would you rate your neck pain?**

No pain	Worst pain possible
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?**

No interference	Unable to carry out
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?**

No interference	Unable to carry out
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

Not at all anxious	Extremely anxious
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?**

Not at all depressed	Extremely depressed
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?**

Have made it no worse	Have made it much worse
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	

**7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?**

Completely control it	No control whatsoever
<span style="margin-right: 10px;">0</span> <span style="margin-right: 10px;">1</span> <span style="margin-right: 10px;">2</span> <span style="margin-right: 10px;">3</span> <span style="margin-right: 10px;">4</span> <span style="margin-right: 10px;">5</span> <span style="margin-right: 10px;">6</span> <span style="margin-right: 10px;">7</span> <span style="margin-right: 10px;">8</span> <span style="margin-right: 10px;">9</span> <span style="margin-right: 10px;">10</span>	





BACK BOURNEMOUTH QUESTIONNAIRE (Bolton JE, Breen AC: The Bournemouth Questionnaire)

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain											Worst pain possible
_____											
0	1	2	3	4	5	6	7	8	9	10	

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference											Unable to carry out
_____											
0	1	2	3	4	5	6	7	8	9	10	

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference											Unable to carry out
_____											
0	1	2	3	4	5	6	7	8	9	10	

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious											Extremely anxious
_____											
0	1	2	3	4	5	6	7	8	9	10	

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed											Extremely depressed
_____											
0	1	2	3	4	5	6	7	8	9	10	

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse											Have made it much worse
_____											
0	1	2	3	4	5	6	7	8	9	10	

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it											No control whatsoever
_____											
0	1	2	3	4	5	6	7	8	9	10	



### Effective April 2023

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive this care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one to one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Signature of Patient (guardian signature if patient is under 18)

\_\_\_\_\_  
Date



3700 Barron Way, Ste 3, Reno NV 89511

P: 775-826-5800 F: 775-826-8466

Email:renobacktohealth@gmail.com

**Notice of Privacy Practices (HIPAA Consent Form)  
Effective April 2023**

By signing below, I understand that some of my health information may be used/and or disclosed by Back to Health Chiropractic and Wellness to carry out treatment, payment, or healthcare operations. For a more complete description of such uses and disclosures I should refer to Back to Health Chiropractic and Wellness's privacy notice entitled "HIPAA Notice of Privacy Practices". I understand that I may view this notice any time prior to signing this form.

This notice describes how health information about you may be used and disclosed and how you can get access to this information, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain in accordance to changes in the law. All changes in this Notice will be prominently displayed and available at our office.

**You have the right to:**

- Get a copy of your medical record
- Correct your medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information with
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**We will never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of chiropractic and treatment notes

**Our responsibilities:**

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it if requested
- We will not use or share your information other than that is described here unless you tell us in writing.

**Check one:**

Back to Health Chiropractic and Wellness does NOT have my permission to share my information.

Back to Health Chiropractic and Wellness CAN release my applicable information to \_\_\_\_\_  
(name of individual)

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Signature of Patient (guardian signature if patient is under 18)

\_\_\_\_\_  
Date