BACK PAIN CHIROPRACTIC

Diane M.Vuotto, D.C.
8130 E. Washington St.
Indianapolis IN 46219

James A. Vuotto, D.C.
2127 E. 71st Street
Indianapolis IN 46220

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

- **Treatment:** We may use your personal health information about you to provide you with treatment or other related services. We may disclose information about you to other employees who are involved in taking care of you. Additionally we may share your personal information to manage or coordinate your care with other providers or hospitals.
- **Payment:** We may disclose and use your health information to obtain payment for services that we have provided to you. We may disclose your personal information in efforts to collect an unsatisfied debt (example; collection company or court).
- **Incidental Use and Disclosure:** We may in fact inadvertently use or disclose your medical information when such use is incident to another use that is permitted by law. For example, while we do have safeguards in place to protect against others overhearing conversations that take place between doctor and staff there may be times that such conversations are in fact overheard. Please be assured that we do have safeguards in place to avoid such situations as much as possible.
- **Individuals involved in your care:** We must disclose your health information to you as discussed in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help you with your health care. We may use your personal information to notify or assist in the notification of a family member or friend responsible for your care, your location, your general condition, or emergency. If you are present, then prior to our disclosure of your information we will provide you with an opportunity to object to such use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable judgements of your best interest in allowing persons to pick up medical supplies, x-rays or forms of health information (ie. auth forms for absence, disability forms, etc.)
- **Workers' Compensation:** We may disclose your health information as authorized by and to the extent necessary to comply with workers' compensation laws.
- **Marketing:** We will not use your information for marketing communication of third parties without your written authorization.
- **As required by Law:** We will disclose your information when required to do so by federal, state or local law. (ie. Abuse, neglect or victim of a crime)
- **Judicial purposes:** We may disclose your information in response to a court or administrative order. We may also disclose information as required in response to a discovery request , subpoena, or other lawful request by someone else involved in a lawful dispute, but only if efforts were made to advise you of the

request or proof of notice to you or your attorney was given in which you were given an opportunity to object to the request.

- **Military:** If you are a member of the military we may release your information to the armed forces personnel as required by the military command authorities.
- **Communication:** We may use or disclose information to make a communication with you to describe a health related service or product offered at Back Pain Chiropractic. We may use your information to provide you with appointment reminders (such as voicemail message, postcards, letters).

PATIENT RIGHTS

- **Right to request Restrictions:** You have the right to request a restriction or limitation to your health information we use or disclose about you for treatment or payment. You also have the right to request a limit on the health care information.

We are not required to agree with your request. If we do agree we will comply with your request unless the information is needed to provide you with emergency treatment.

To make a restriction request, you must make your request in writing to Dr. Vuotto. In your request you must be specific in telling us (1) WHAT INFORMTION IS LIMITED (2) WHETHER YOU WANT TO LIMIT OUR USE, DISCLOSURE OR BOTH; AND (3) TO WHOM THE LIMITS APPLY.

- **Alternative Communication:** You have the right to request that we communicate with you or your responsible parties about your health in alternative ways or at a certain location.

To make such a request you must make your request in writing to Dr. Vuotto. We will not ask for a reason for this request. We will accommodate all reasonable requests. Your request should specify how or where you are to be contacted.

- **Right to inspect and copy:** You have the right to inspect and copy health information that may be used to make decisions about your health care.

To make such a request you must make your request in writing to Dr. Vuotto. If you make a request for a copy we may request a fee for the cost of copying or other supplies associated with your request.

- **Right to Amend:** You have the right to request that we amend your health information.

To make such a request you must make your request in writing to Dr. Vuotto. (We reserve the right to deny your request under certain circumstances.)

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve this right to information we already have for you as well as any information in the future. We will clearly post a copy of the current notice in a clear and prominent location to which you have access. This notice will be available to you upon request. In addition if we revise our notice you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your rights have been violated, you may file a complaint with our office or with the Secretary of the Dept. of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions regarding this complaint please contact;

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Patient Authorization regarding chiropractic care being provided in an "open therapy" environment

It is the practice of this office to provide chiropractic care in an open therapy environment. Open therapy involves several patients being seen in the same therapy room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is not the environment that is used for taking a history, examination, report of findings, or adjusting. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in the open environment are incidental matters. In the event that you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be treated in an open environment, other arrangements will be made for you. Your decision will in no way have any adverse effect on your care from Dr. Vuotto or on your relationship with our staff.

Your signature indicates your authorization of this activity.

X _____

Name (printed) Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

X _____

Name (printed) Signature Date

BACK PAIN CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION

DATE:_____

PATIENT NAME: _____ SS# _____

BIRTH DATE: ___/___/___ Age:____ GENDER: M F MARITAL STATUS: M S D W

PATIENT'S ADDRESS: _____ Apt:_____

City: _____State: _____ Zip: _____

Email: _____
May we email you? Yes No May we text you? Yes No

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____

Occupation_____ Employer _____

Name of spouse_____ Spouse's Occupation_____

Emergency contact_____ Phone_____

How did you hear of us? Family Doctor___Friend/Relative____Internet____Other_____

Referred by_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance companies and me, not between my insurance companies and this office. I authorize this office to release any medical information and complete any reports necessary. I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor fees for service will be immediately due and payable.

Health Insurance _____

Patient Signature_____Date_____

MEDICAL HISTORY

Is the condition due to an auto-accident? Y N Date of Accident: _____
Number of days missed from work_____
Date symptoms first appeared_____

Height_____ Weight_____

DO YOU HAVE A PACEMAKER? Yes _____ No _____

Please check all that apply:

___ Anemia
___ Arthritis
___ Blood Clots
___ Digestive Disorders
___ Gall Bladder/Stones
___ Hernia
___ Kidney Problems/Stones
___ Rheumatic Fever
___ Thyroid Disease
___ Anxiety/Depression
___ Asthma
___ Cancer
___ Dizziness
___ Headache
___ High Blood Pressure
___ Lung Problems
___ Seizures
___ Other (describe below)
___ HIV/AIDS
___ Backache
___ Diabetes
___ Heart Problems
___ Hepatitis/Liver Problems
___ Nervousness
___ Numbness
___ Sinus problems

Past Surgeries or prior Hospitalizations: _____
_____

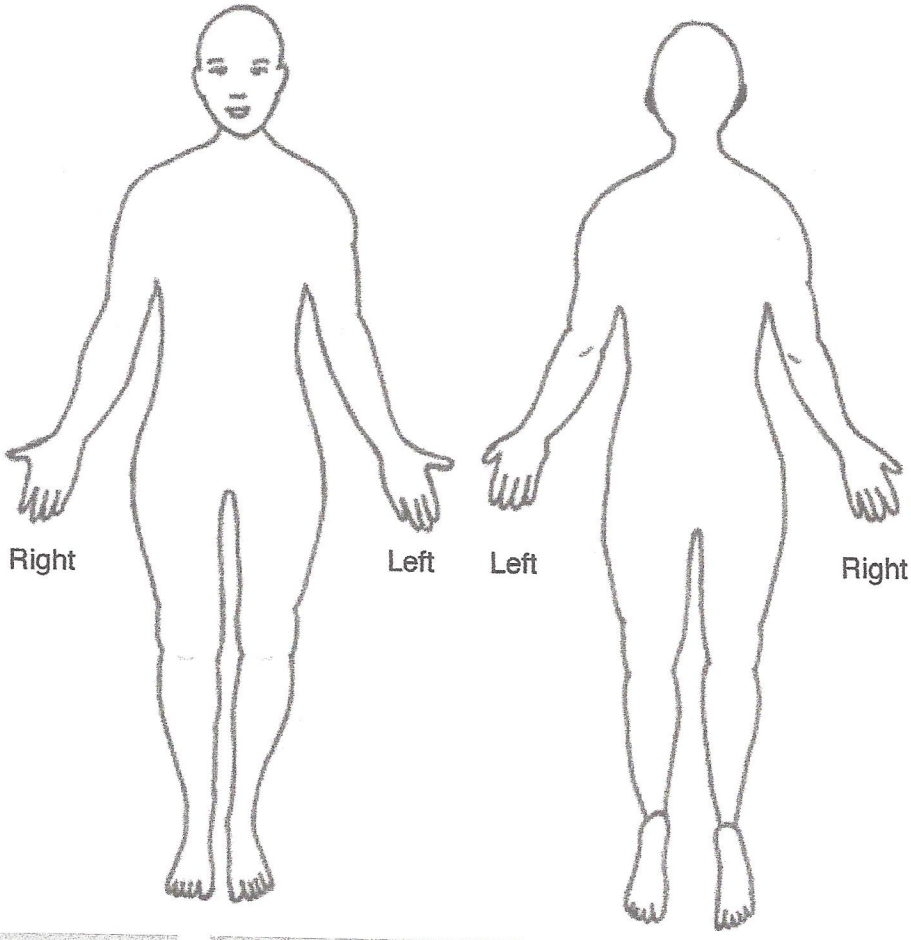
Current Medications: (including over-the-counter, prescriptions, birth control pills):
1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____

Please explain briefly why you are here today: _____
_____

Pain Drawing

Name: _____ Date: _____.

Mark the areas of pain



Check Quality of Pain	
	Achy
	Burning
	Dull
	Sharp
	Stiff
	Other:

Grade Major Compaint	
Worst	0 1 2 3 4 5 6 7 8 9 10
Best	0 1 2 3 4 5 6 7 8 9 10
Other Complaints	

What Alleviates the pain					
	Nothing		Massage		Walking
	Cold		Movement		Sleeping
	Hot		Rest		

Patient Signature: X _____