82 Maxcy Plaza Circle
Haines City, Florida 33844
Ph: 863-421-9700 Fax: 863-421-1953

APPLICATION FOR CARE

Date: ____________________

Name: ______________________________ Home Phone: ____________________

Address: ______________________________ Work Phone: ____________________

City, State, Zip: ______________________________ Cell Phone: ____________________

Email Address: ____

Birth Date: ____________ Age: ______ SSN: ______________ Marital Status: S M D W

Occupation: ______________ # of Children: ______ Spouse's Name: ______________

Name & Number of Emergency Contact: ______________________________

Relationship: ______________________________ Do you have insurance? ☐ Yes ☐ No

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of **1** to **10** (zero = no pain; 10 = worst pain)

1. ______________________________ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

2. ______________________________ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

3. ______________________________ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

4. ______________________________ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? ______________________________

When is the problem at its worst? ☐ early AM ☐ mid-morning ☐ mid-day ☐ early evening ☐ late evening

How long does it last? ☐ constant throughout day ☐ I experience it on and off during the day

☐ it comes and goes throughout the week

How did the injury happen? ______________________________

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Has the condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

If yes, when: ____________ and by whom? ______________________________

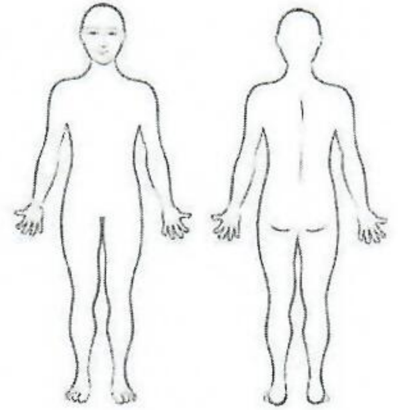
How long were you under care: ______________ What were the results: ______________

Name of previous chiropractor: ______________________________ ☐ N/A

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R = Radiating
B = Burning
D = Dull
T = Tingling

A = Aching
N = Numbness
S = Sharp/Stabbing



What relieves your symptoms? ____________________
What makes them feel worse? ____________________

Please list any restricted activities, your current activity level, and your usual activity level:

RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
ex: walking	*ex: walk half mile 2x/week*	*ex: walk one mile 4x/week*

Identify any other injuries to your spine, minor or major, that the doctor should know about: ____________________

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently taking: ____________________

Women: Is there ***any chance*** that you are pregnant? ☐ Yes ☐ No

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No
If yes, how many times? ________________ When was the last episode? ________________
How did the injury happen? ____

Have you tried any other forms of treatment: ☐ Yes ☐ No
If **yes**, please state **what type** of treatment: ________________, and who provided it: ________________
How long ago? ____________ What were the results: ☐ favorable ☐ unfavorable -- please explain: ________

Please identify any and all types of jobs, activities, or events you have experienced in the past that have imposed any physical stress on you or your body: ____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P = in the Past **C** = Currently **N** = Never have had:

___ broken bone	___ disability	___ cancer	___ rheumatoid arthritis
___ osteoarthritis	___ diabetes	___ cerebrovascular	___ heart attack
___ dislocations	___ tumors	___ thyroid disorder	___ other: ________

Please identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	Condition	How Long Ago	Type of Care Received	By Whom
INJURIES				
SURGERIES				
CHILDHOOD DISEASES				
ADULT DISEASES				

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes ☐ daily ☐ weekends ☐ occasionally ☐ never
2. Alcoholic beverage consumption: ☐ daily ☐ weekends ☐ occasionally ☐ never
3. Recreational drug use: ☐ daily ☐ weekends ☐ occasionally ☐ never
4. Hobbies/recreational activities/exercise/sports: ________________________________

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
   If **yes** whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sibling(s) ☐ son(s) ☐ daughter(s)
   Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ________________

Quadruple Visual Analogue Scale

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the source for each complaint (see example below).

Example:

			Headache			Neck			Low Back			
No pain	0	1	(2)	3	4	(5)	6	7	(8)	9	10	Worst Possible Pain

---

1. What is your pain level **right now**?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

2. What is your **typical** or **average** level of pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

3. What is your pain level **at its best** (how close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

4. What is your pain level **at its worst** (how close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Other Comments: ______________________________

____

____

OATS Score: ________ %

ACTIVITIES OF DAILY LIVING

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life.

Reading/Concentrating	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Taking out Garbage	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying (groceries, children, etc.)	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting (groceries, children, etc.)	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bending	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand Position	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand to Sit Position	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please mark the listed items below as: **P** (Past) **C** (Currently) **N** (Never)

____ headache
____ neck pain
____ jaw pain, TMJ
____ shoulder pain
____ upper back pain
____ mid back pain
____ low back pain
____ hip pain
____ back curvature/scoliosis
____ numb/tingling arms
____ numb/tingling hands/fingers
____ numb/tingling legs
____ numb/tingling feet/toes
____ knee problems
____ foot problems
____ swollen/painful joints
____ frequent colds/flu
____ pain w/ cough/sneeze
____ allergies
____ sinus/drainage problem

____ convulsions/epilepsy
____ tremors
____ dizziness
____ loss of balance
____ fainting
____ double vision
____ blurred vision
____ ringing in ears
____ hearing loss
____ asthma
____ difficulty breathing
____ lung problems
____ heart problems
____ heartburn
____ chest pain
____ high blood pressure
____ low blood pressure
____ ulcers
____ digestive problems
____ colon trouble

____ diarrhea/constipation
____ kidney trouble
____ gallbladder trouble
____ liver trouble
____ prostate problems
____ impotence
____ menstrual problems
____ PMS
____ menopausal problems
____ depression
____ irritable
____ bed wetting
____ skin problems
____ mood changes
____ learning disability
____ ADD/ADHD
____ eating disorder
____ trouble sleeping
____ Hepatitis (A, B, C)
____ other: ____________

I hereby authorize payment to be made directly to Ridge Chiropractic Care for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and affecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Ridge Chiropractic Care for any and all services I receive at this office that are not covered under a healthcare plan.

______________________________ Signature of Patient or Authorized Person

__________ Date

______________________________ Signature of Doctor

__________ Date

Notes: ____

Ridge Chiropractic
82 Maxcy Plaza Circle Haines City, Florida 33844
(863) 421-9700 F (863) 421-1953

Auto Injury Form

GENERAL INFORMATION

Date: ___/___/______

Full Name: ______________________________ **SS #:** ____________________
First Name   Middle Name   Last Name

Address: ____
№   Street Name   Apt №   City   State   Zip Code

Age: _____ **Date of Birth:** __________ **Sex:** Male Female **Marital Status:** __________

Home Phone: ______________ **Cell Phone:** ______________

Work Phone: ______________ **Email Address:** __________@__________.com

Employer: ____________________ **Occupation:** ____________________

Emergency Contact: ______________ **Contact Phone** __________ **Relation:** __________

Primary Care Physician ______________ **Address** ______________ **Phone #** __________

ACCIDENT INFORMATION:

Date of accident: ______________ **Make & model of the vehicle you were in:** ______________

Were you a pedestrian: __________ **Name of your own Auto Insurance Co:** ______________

Make & model of the other vehicle: ______________ **Speed of the other vehicle:** __________

City & State the accident occurred: ______________

Which Police Dept. responded to the scene: ______________ **Was a report filed:** __________

Were you punched in (on the clock) for work at the time of the accident? Yes No

Were you in a company Vehicle? Yes No **Was this accident in a parking lot?** Yes No

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the vehicle at the time of the accident? __________

Were you wearing a seat belt? Yes No If yes, what type: Lap Shoulder

Did the airbags deploy? Yes No **Are there any injuries from the airbag?** ______________

Was your vehicle stopped moving **at the time of impact? Speed you were traveling?** __________

Were you: Surprised by impact braced for impact

At the time of impact were you:

Looking straight ahead Looking to the left Looking to the right Looking down Looking up

Was impact from: Front Rear Left Right other: ______________

Did your car impact another vehicle? Yes No **Did your car impact a structure?** Yes No

Please describe the accident in your own words: ________________________________

____

____

Did any part of your body strike anything in the vehicle? Yes No

If yes, explain: ____

PATIENT CONDITION & TREATMENT:

Did you lose consciousness? Yes No **If yes, for how long?** ____________________

What were your symptoms following the accident? ____________________

Did you go to the hospital? Yes No **If yes, name of hospital:** ____________________

When did you go? Immediately after accident Later that day Next day other: ____________________

Transported by ambulance? Yes No **Do you have any of the following:** Cuts Scrapes Bruises

Were x-rays performed? Yes No **If yes, which body part?** ____________________

Were any other tests performed? Yes No **If yes, what tests?** ____________________

Was medication prescribed? Yes No **If yes, what medications?** ____________________

Are you pregnant? Yes No **If yes, due date:** __________

Do you smoke? Yes No **If yes, how much:** _______ **Drink alcohol?** Yes No **If yes, how much:** _______

SYMPTOMS/INJURIES:

Have you been able to work since this injury? Yes No **How many workdays have you missed?** _______

Please circle your symptoms since your injury:

Headaches **Neck pain** **Neck stiffness** **Jaw problems**

left/right Arm pain **left/right Shoulder pain** **left/right Hand/finger pain/numbness**

Mid-back pain **Back stiffness** **Chest pain** **Low back pain** **left/right Hip pain**

left/right Leg pain **left/right Knee/Ankle pain** **left/right Foot/Toe pain/numbness**

Dizziness **Nausea** **Fatigue** **Sleep difficulty** **Abdominal pain**

Difficulty turning head to the right/left **Vision blurred** **Hearing loss / Balance**

Does coughing/sneezing increase your pain? Yes No

Are your symptoms getting worse? Yes No **Is it constant or does it come and go?** __________

Rate the severity of your pain on a scale from 1 (lease pain) to 10 (severe pain) ______________

Type of pain: Sharp Cramping Dull Throbbing Burning Stabbing Grabbing

INSURANCE/ATTORNEY INFORMATION:

What is the Name/Policy # of your auto insurance?

____

What is the Name of other parties auto insurance?

____

Do you have health insurance? Yes No
If yes, please give your insurance card to the front desk.

POLICE:

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No
If yes, please give the front desk a copy

Was a traffic violation issued? Yes No
If yes, to whom? ______________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____________________ Signature of Patient, Parent, Guardian or Personal Representative

____________________ Date

____________________ Please print name of Patent, Parent, Guardian or Personal Representative

____________________ Relationship to Patient

Notice of Initiation of Treatment

Patient Name: ______________________________ **DOB:** ________________

PHYSICIAN: Dr. Brett Summers, D.C.

INSURED: ____

DATE OF LOSS: ____

INSURANCE COMPANY: _____________________________________

CLAIM NUMBER: ____

To Whom It May Concern:

Please be advised that I have been consulted by and have been rendering medical treatment to the above referenced patient, with the patients first date of treatment occurring on ____________.

Enclosed, please find a direction to pay, which the patient has directed you to send all payments for services rendered to the undersigned. The patient has also granted us a lien on the benefits.

In accordance with F.S. 627.736 (5) (b), I will be timely submitting the bills.

Thank you,

________________________________ ________________

Dr. Brett Summers, D.C. Date

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Name *(PRINT or TYPE)*	Signature	Date
Brett Summers, D.C.		

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Assignment of Benefits, Lien, Cause of Action, and Authorization

Patient Name: ____________________________ DOB: _____________ Claim # __________________________

I hereby authorize and direct you, my insurance company and/or attorney, to pay directly to Ridge Chiropractic/Champion Wellness Center of Haines City, LLC (Assignee) such sums as may be due and owing Assignee for services and treatment rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability and benefits, personal injury protection, medical payment benefits, no fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict which may be paid to me as a result of injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's service provided.

In the event my insurance company is obligated to make payments to me upon the charges made by Assignee for its services denies or reduces payment, I direct my insurer to escrow any personal injury protection and/or medical payments benefits it might have or that might have or that might exist in my favor against such company. I further authorize Assignee to file suit for such benefits assigned herein and to compromise, settle, or otherwise resolve said claim or cause as they see fit.

In the event of litigation or arbitration, I agree to cooperate with Assignee and any attorney retained by them in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, arbitration, or trial of the case, and execution of releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this assignment by taking a position inconsistent with Assignee's pursuit of payment.

I understand that I remain personally responsible for the total amounts due Assignee for its services which are not otherwise required by the law to be paid by my insurance company and in accord with the policy of insurance issued to me. I further understand and agree that this Assignment of Benefits, Lien, Cause of Action, and Authorization does not constitute any consideration for Assignee to await such payments which I may otherwise owe, and they may demand such payments from me immediately upon rendering services at their option.

I authorize Assignee to release information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under Assignment of Benefits, Lien, Cause of Action, and Authorization. I authorize, grant, and designate that the above mentioned Assignee be given special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment for all services rendered by Assignee directly to Ridge Chiropractic/Champion Wellness Center of Haines City, LLC.

____

Print Patient Name

____

Patient/Guardian Signature

____

Date

Ridge Chiropractic
FINANCIAL AGREEMENT

Dear Patient:

We have attempted to provide you with the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Ridge Chiropractic.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at Ridge Chiropractic:

✓ PERSONAL INJURY - Although my insurance or lawsuit may eventually pay Ridge Chiropractic in full for services rendered, I agree to take full responsibility for my account balance, whether active or inactive as a patient.

____

Print Patient Name

____ __________________

Patient/Guardian Signature Date

Ridge Chiropractic
82 Maxcy Plaza Circle Haines City, Florida 33844
(863) 421-9700 · (863) 421-1953 (Fax)

Date: ______________

Authorization for Release of Records

To: ____

Phone: ______________________ Fax: ______________________

Patient Name: ______________________ Date of Birth: ____________

Patient Phone Number: ______________________

Please release the following medical information: ______________________

____

To be released to: **Ridge Chiropractic**
82 Maxcy Plaza Circle
Haines City, FL 33844
Phone: (863) 421-9700
Fax: (863) 421-1953
rchiropractic1@gmail.com

Patient/Guardian Signature: ______________________ Date: ____________

CONFIDENTIALITY NOTICE:

This facsimile and all contents contain information belonging to Ridge Chiropractic, which may be privileged, confidential, or otherwise protected from disclosure. The information is intended to be for the addressee only. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled. If you are not the addressee, any disclosure, copy, distribution or action taken in reliance on the contents of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately by calling them at the above number and destroy the original facsimile and all its copies.

Ridge Chiropractic Care NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk staff. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room. Often, private conversations require a specific appointment time outside of our normal adjusting hours. Please see a front desk staff member, and we will be happy to schedule this for you.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or notify you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive (detailed) privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call us at 813-409-3304. If were unavailable, you may make an appointment with our receptionist within 72 hours, or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS - Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Please initial here: ______ if you wish to retain your copy of Page 1 of this notice.

Ridge Chiropractic Care's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Ridge Chiropractic Care's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

PRINT Patient's Name ______________________ Date of Birth ______________ Chart# ______________

Signature of Patient or Guardian ______________________ Date ______________

Witness ______________________ Date ______________