APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACITC

Name: _____ DOB: ____ -____ - _____ Age: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

□ Home □ Cell: _____ SSN: _____ - _____ - _____ * SSN Required for 3rd party billing

Marital Status: □ Single □ Married □ Widow E-Mail: _____

Do you have insurance? □ Yes □ No Insurance Co: _____ Insurance ID: _____

Physician: _____ Phone Number: _____

Would you like reports/updates sent to your Physician? □ Yes □ No

Employer: _____Occupation: _____ Work Number:_____

Spouses Name: _____ Spouses DOB: ____ -____ - _____ # of children: _____

Emergency Contact: _____ Phone: _____ Relationship to you: _____

What is your smoking status? □ Current Daily Smoker □ Current Some Day Smoker □ Former □ Never

Alcoholic Beverage Consumption: □ Yes □ No

Check the box to the condition(s) that brought you to the office:

□ Headache: Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

□ Neck: Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

□ Upperback: Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

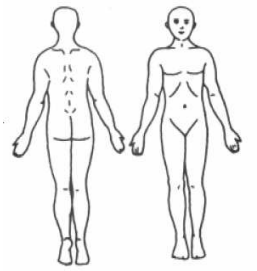
□ Midback: Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

□ Lowback: Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

□ _____ Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

□ _____ Pain level (0-10) ____ Frequency: 25% 50% 75% 100%

Mark an **X** on the picture where you are feeling pain or symptoms:



Date problem(s) began: _____ How problem(s) began: _____

Have you had spinal X-Rays, MRI, CT SCAN for your area(s) of complaint? □ Yes □ No

If yes: Dates taken _____ What area(s) _____

Please mark all the following that apply: Mark a **P** for Personal History **F** for Family History or **B** for Both

____ Alcohol/Drug Dependence
____ High Blood Pressure
____Taking Birth Control Pills
____ Cancer/Tumor
____ Prostate Problems
____Currently Pregnant
____ Pain Unrelieved by position/rest
____ Rheumatoid Arthritis
____ Recent Fever
____ Stroke (Date _____)
____Dizziness/Fainting
____ Osteoporosis
____Menstrual Problems
____ Abnormal weight □gain □loss
____Pain at Night
____ Diabetes
____ Cortisone/Prednisone
____ Numbness in Groin/Buttocks
____ Epilepsy/Seizures
____ Urinary Problems
____ Morning pain/Stiffness
____ Visual Disturbances

SURGERIES:

_____

MEDICATIONS:

_____

I hereby authorize payment to be made directly to Gresham Family Chiropractic (GFC) 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 effecting 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 GFC for any and all services I receive at this office.

_____ _____ _____-_____-_____

Patient Printed Name **Patient or Authorized Person's Signature** **Date Completed**

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACITC

INITIAL EVALUATION – Workers Compensation

Date of accident: _____ Time of accident: _____

Location of accident: □ on □ at □ in _____

Was the patient dazed? □ Yes □ No

Did the patient lose consciousness? □ Yes □ No

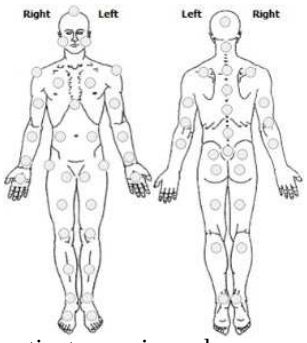
If yes, for how long? _____

Was the head injured? □ Yes □ No

Other part(s) injured: _____

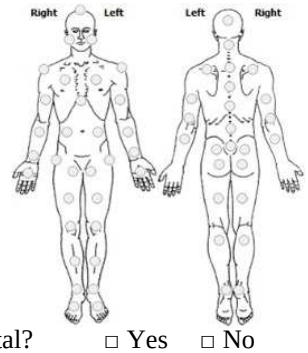
If applicable, mark the diagram with the following:

(BR) Bruises
(A) Abrasions
(L) Lacerations
(S) Swelling
(BL) Bleeding
(F) Fracture
(BU) Burns



Immediately after the accident patient experienced: □ Headaches □ Neck pain □ Low back pain

And pain in:



Did the patient go to the hospital? □ Yes □ No

What hospital? _____

Transportation to the hospital by: □ Drove myself □ Someone else □ Ambulance □ Police

Tests done at the hospital: □ X-Rays □ MRI □ CT-SCAN □ Lab Work

Other tests: _____

Any prior doctor for this accident? □ Yes □ No

Name: Dr. _____
Tests/procedures: _____
Name 2: Dr. _____
Tests/procedures: _____
Name 3: Dr. _____
Tests/procedures: _____

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACITC

Financial Policy

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest period of time.

Fees: Our service fees are based on values determined to be usual and customary for this geographic region. Our fee schedule for the most common services we provide is available upon request. There is a $20 statement fee. Unpaid balances are subject to an 18% interest fee per annum (1.5% monthly). There is a $25 fee for all returned checks.

First Visit: Fees for treatment rendered are payable, due in full, and expected at the completion of the first appointment.

Missed Appointment: A $46.00 fee will be posted to your account for any missed or cancelled chiropractic appointment without24 hour advance notice being given. A $29.00 fee will be posted to your account for any missed or cancelled massage appointment without 24 hour advance notice being given. Payment for missed appointment fees is your responsibility and not the responsibility of your insurance company.

Self-Pay Accounts: Payment at the time of service is expected unless prior arrangements have been made. We accept Visa, MasterCard, and Discover, as well as cash payments and personal checks.

Health Insurance: As a courtesy, we will bill your personal health insurance company should you choose to assign payments directly to the doctor. Such payments will be applied directly to your account. You are required to pay your co-pay at the time of your visit. Estimated co-insurance portions and any unpaid deductible, (up to the amount of services rendered for that day, based upon our usual and customary fee schedule,) is due at the time of your visit. All necessary payments not made at the time of service, as directed above, are subject to a $20.00 statement fee. Any amount remaining once your insurance company has paid is your responsibility, including any amount that they have denied payment for any reason. A statement will be sent to you for the remaining balance due on your account. All accounts are due 30 days net. If you do not pay your balance within 30 days of statement issue, a $20.00 billing charge will be included for each additional 30-day billing cycle that your account remains unpaid. If you do not choose to assign payment directly to the doctor, your account will be handled as a self-pay account as described above. One monthly statement will be made available to you per month. Additional statements are $20.00.

Medicare: All Medicare billings will be handled by our account manager if you direct this office to do so. **This office has chosen not to accept assignment. This means all services performed are the responsibility of the patient and due at the time of service**. We will bill Medicare for you and direct them to send payment directly to you. It is also the patient's responsibility to bill their secondary insurance or Medicare supplement. Medicare **does not** provide for payments on: maintenance care, x-rays, examinations, physiotherapy, orthopedic supports or dietary supplements when provided by a chiropractor. Medicare may deny payments on all or part of any treatment received in this clinic based upon Medicare guidelines and "medical necessity". You are still responsible for payment.

Automobile Insurance: If your injuries were sustained in a motor vehicle accident, your medical expenses should be covered by the Personal Injury Protection (PIP) coverage of the vehicle you were in. It is our office policy and Oregon Statute to bill medical expenses to the PIP carrier of the vehicle you were in, not the other driver's insurance, regardless of fault. If you have any questions regarding this, we can refer you to the office of the Oregon Insurance Commissioner. You must complete and submit the PIP benefits application supplied by the insurance company in order for medical expenses to be paid to this office. If you do not submit the PIP benefits application, all medical expenses in this office become your responsibility and are subject to the above stated policies. If your PIP benefits are denied for any reason, all incurred expenses become your responsibility. It is our office policy to not carry an account balance past one year of the motor vehicle accident. Representation of an attorney who has either signed an attorney lien or a letter of protection directing payment to this office out of the settlement is required. A minimum monthly payment of $ 100.00 will be expected on account balances. A monthly statement fee of $20.00 will apply on each monthly billing.

Worker's Compensation Insurance: If your injuries were sustained in a work related incident, your medical expenses may be covered by your company's Worker's Compensation Insurance. You and your employer must submit documentation of the incident to file a claim for benefit eligibility. Payments for supports and supplements are the patient's responsibility. Unaccepted claims are the patient's responsibility to maintain a zero account balance until the claim is either accepted or denied. Acceptance of the claim may take as long as 60 working days. During this time, the patient is responsible for all charges accrued in this clinic. In such a case of claim denial, any and all previously unpaid amounts will become immediately due in accordance with the above stated account policies. Patients will be refunded all amounts previously paid once this office has received in writing from the responsible insurance company that the claim has been accepted for the condition the patient was being treated for. If the claim is accepted for any condition other than the conditions being treated for in this clinic, any portions paid toward the non-accepted condition will be placed towards a self-pay account and will not be refunded.

Patient Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACITC

Informed Consent to Care

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 the 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, strokes, dislocations, strains, and sprains. 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. Arterial dissections occur in 3-4 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 chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. 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. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These 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 content, 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 Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACITC

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LEIN AND TREATMENT AGREEMENT.

Consideration: In order to facilitate the ability of the Office to collect its charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien, I herby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against the Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive and proceeds from any Payer to the Office and further grant a contractual lien to the Office with any respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the Secretary of State or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms: I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to the Office upon its demand. Unless mutually agreed in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitation, which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my charges to any and all Payers, including, without limit, my health benefit plan. I understand, however that in the event that my charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs or discounts issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee, which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located and performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-convenes.|

I agree that each and every provision of this Agreement is reasonable necessary for the protection of the rights and interest of the Office and myself. However, should any provision of this Agreement be found to be "invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless; remain in full force and effect"

Definitions: For the purpose of this Agreement, the following terms shall have the following meaning: "Office" shall refer to Gresham Family Chiropractic located at 575 NE 2nd Street Gresham, OR 97030. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, tortsfeasor, individual, and any other entity, which may elect to be obligated to payer disburse Proceeds to me, either now or in the future, for any reason. "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, and the proceeds relating to the following benefits, plans, or coverage: individual and group health benefits, Medicare, Medicaid, Worker's Compensation, disability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collections Costs incurred by the Office, 18% interest on outstanding Charges, and any other Charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any Payer.

Patient Name (please print) _____

Patient Signature _____ Date _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print) _____

Parent/Guardian Signature: _____ Date _____

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay the debt owed and in consideration for receiving future care at or by the clinic and doctors whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the ____ day of _____, 20____, to the extent of the cost of treatment provided or to be provided to me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due to the Clinic and to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately pay and protect the Clinic. I herby further give, grant, assign, and covey a legally enforceable interest and lien on my case to the Clinic against any and all proceeds any and all causes of action, settlements, judgments, or verdicts by which I may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment, or verdict for which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic is not responsible for paying any of my attorneys' fees and the Clinic does not agree to pay my attorney(s) any attorney's fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTLING MY ATTORNEY(S) TO PROTECT THE CLINIC'S INTEREST AT THE THIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW THAT I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT CONVEYANCE, AND LIEN."

_____	_____	_____
Patient Name (Print)	Patient Signature	Date Completed

DR. ROBERT W. RAMSEY, DC PC
575 NE 2nd St, GRESHAM, OR 97030
(503) 667-6744

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES:

This Notice is in effect as of April 14, 2003.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for seven years.

_____

Patient Name (Please print)

_____

Patient Signature

_____ _____

Signature (minor) *Date*
Parent, Guardian or Patient's legal representative

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF APPOINTMENT REMINDERS:

I acknowledge that I was provided a copy of the Notice of Appointment Reminders and that I have read them or declined the opportunity to read them and understand the Notice of Appointment Reminders. I understand that this form will be placed in my patient file and maintained for seven years.

_____

Patient Name (Please print)

_____

Patient Signature

_____ _____

Signature (minor) Date
Parent, Guardian or Patient's legal representative

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

(This notice describes how medical information about you may be used and disclosed and how you can get access to this information.)

The effective date of this notice is April 14th, 2003.

PLEASE REVIEW IT CAREFULLY!

In this notice we use the terms "we", "us", "our" and Gresham Family Chiropractic (GFC) as noted in section V.

I. Uses and Disclosures

A. We may use and disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:

Treatment: Example: We may use your health information within our offices to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services. Should you ever be hospitalized, we may provide the hospital staff with the health information required to provide you with effective treatment.

Payment: Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: Example: We may use your health information to conduct internal quality assessment and improvement activities for business management and general administrative activities.

B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement, under the following circumstances:

- If we provide services to you while you are inmates.
- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend us to treat you.

-If we need to notify or assist in the notification of a family member, personal representative or another person responsible for your care of your location, general condition, or death.

-If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

-If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of abuse, neglect, child abuse, or domestic violence.

-If we are required to disclose your health information to the Food and Drug Administration.

-If we are required to disclose your health information to your employer to evaluate whether you have a work- related injury or illness.

-If we are required to disclose your health information to a health oversight agency for oversight actives required by law.

-If we are required to disclose your health information in response to a court order or a subpoena.

-If we are required to disclose your health information to a coroner, medical examiner or funeral director.

-For research purposes: If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

-If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

With the exception of the above circumstances, any use and disclosure of your health information will be made only with your written authorization. Your written authorization may be revoked, in writing, at any time except to the extent that we have provided services or taken action in reliance on your authorization.

II. Your Rights

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications: You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy: You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation. If we don't have the record you asked for, but we know who does, we will tell you who to contact to request it.

Right to Amend: You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to Receive an Accounting: You have the right to receive an account of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. This accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made in our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.
Right to Receive Notice: You have the right to receive a paper copy of this Notice upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address listed below. We will not take any action against you for filing a complaint.

V. How to Contact US

If you would like further information about our privacy practices, please contact:

Gresham Family Chiropractic
575 NE 2nd Street,Gresham, OR 97030
503-667-6744

Dr. Robert W. Ramsey
Gresham Family Chiropractic
575 NE 2nd ST, Gresham, OR 97030
Ph: 503-667-6744 | Fx: 503-661-7896

Notice of Appointment Reminders

We, the Doctor and Employees of Gresham Family Chiropractic (GFC), may use and disclose information in your medical record to contact you as a reminder that you have an appointment at GFC. This reminder will be via call, text, or e-mail, and will include the date and time of the appointment(s). If a call is made and not answered, we will leave a message stating the date and time. If the call is made and you are unavailable we will leave a message with the individual who answers the phone. However, you may request, in writing, that we provide such reminders only in a certain way, a certain place, or to certain people.

Please send such request(s) to:

Gresham Family Chiropractic
575 NE 2nd St, Gresham, OR 97030