APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC

Name: _____ DOB: ____-____-_____ Age: ____ □ Male □ Female
Address: _____ City: _____ State: ____ Zip: _____
□ Home □ Cell: _____ Would you like Text Message Reminders: □ No □ Yes
If yes, who is your carrier: □ AT&T □ Cricket □ Sprint □ T-Mobile □ Verizon □ Other: _____
Status: □ Married □ Divorced □ Widowed □ Single E-Mail: _____
Do you have insurance: □ No □ Yes Insurance Co: _____
Insurance ID: _____ SSN: _____-_____-_____ * Required for 3rd party billing
Would you like reports/updates sent to your physician? □ No □ Yes
If yes,: Physician: _____ Physician's number: _____
Employer: _____Occupation: _____ Work Number: _____
Spouses Name: _____ 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: □ No □ Yes Caffeinated Beverage Consumption: □ No □ Yes

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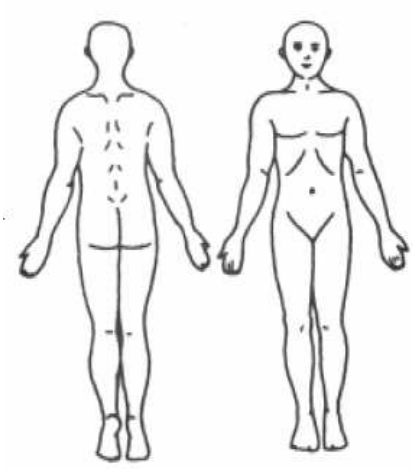
WORK RELATED ACCIDENT INFORMATION

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



What specifically brought you to the office:

_____

Date Problem(s) Began: _____
How Problem(s) Began: _____
Date accident happened: _____
Time accident happened: _____ : _____ am / pm
Location: □ On □ At □ In : _____
Were you dazed? □ No □ Yes
Did you lose consciousness? □ No □ Yes
If yes, for how long? _____ □ *Minutes* □ *Hours*
Was your head injured? □ No □ Yes
Other parts injured: *(Bruised, bleeding, swelling, lacerations, etc.)*

_____

Immediately after, experienced: □ Headache □ Neck Pain □ Low Back Pain
Did you go to the hospital: □ No □ Yes
If yes, which hospital: _____
Transported by:
□ *Ambulance* □ *Drove Self* □ *Somebody Else* □ *Police* □ *Helicopter*
Tests done at hospital:
□ *X-Rays* □ *MRI* □ *CT-Scan* □ *Lab Work* □ *Other:* _____
Any prior doctor for this accident: □ No □ Yes *If yes, who:*

_____

Do you feel your condition is: □ Improving □ Unchanged □ Getting worse
Have you lost time from work: □ No □ Yes *If yes, for how long:* _____ *day(s)* _____ *week(s)* _____ *month(s)*
Can you perform physical activities: □ Yes □ No *If no, because of:* □ *Pain* □ *Weakness* □ *Stress*

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC

What activities of daily living are you having trouble with:

_____

Can you sleep without problems: □ No □ Yes

Do you waken because of pain: □ No □ Yes

If yes, where: _____

Did you have sleep problems before: □ No □ Yes

*When filling in complaints, please list ONE complaint at a time.

Complaint #1: _____

Pain Level: _____ (1-10 – ten being the worst pain imaginable) **Came on**: □ Gradually □ Immediately

Is Getting: □ Same □ Better □ Worse **Intensity**: □ Mild □ Moderate □ Severe **Frequency**: 25% 50% 75% 100%

Describe the feeling:□ Dull □ Sharp □Aching □Shooting □Spasm □Throbbing □Burning □Numbing □Tingling □Other: _____

Please mark all of the following that apply: Mark **A** for Aggravates or **R** for Relieves

___ Morning Time ___ Afternoon Time ___ Bending Forward ___ Bending Back ___ Bending Left ___ Bending Right

___ Twisting Left ___ Twisting Right ___ Coughing ___ Sneezing ___ Straining ___ Standing

___Lifting ___Sitting ___ Heat ___ Ice ___ Rest ___ Lying Down ___ Medications

Pain Radiates to: *(Please check all that apply)*

___ Head ___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___ Leg ___ Foot

Complaint #2: _____

Pain Level: _____ (1-10 – ten being the worst pain imaginable) **Came on**: □ Gradually □ Immediately

Is Getting: □ Same □ Better □ Worse **Intensity**: □ Mild □ Moderate □ Severe **Frequency**: 25% 50% 75% 100%

Describe the feeling:□ Dull □ Sharp □Aching □Shooting □Spasm □Throbbing □Burning □Numbing □Tingling □Other: _____

Please mark all of the following that apply: Mark **A** for Aggravates or **R** for Relieves

___ Morning Time ___ Afternoon Time ___ Bending Forward ___ Bending Back ___ Bending Left ___ Bending Right

___ Twisting Left ___ Twisting Right ___ Coughing ___ Sneezing ___ Straining ___ Standing

___Lifting ___Sitting ___ Heat ___ Ice ___ Rest ___ Lying Down ___ Medications

Pain Radiates to: *(Please check all that apply)*

___ Head ___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___ Leg ___ Foot

Complaint #3: _____

Pain Level: _____ (1-10 – ten being the worst pain imaginable) **Came on**: □ Gradually □ Immediately

Is Getting: □ Same □ Better □ Worse **Intensity**: □ Mild □ Moderate □ Severe **Frequency**: 25% 50% 75% 100%

Describe the feeling:□ Dull □ Sharp □Aching □Shooting □Spasm □Throbbing □Burning □Numbing □Tingling □Other: _____

Please mark all of the following that apply: Mark **A** for Aggravates or **R** for Relieves

___ Morning Time ___ Afternoon Time ___ Bending Forward ___ Bending Back ___ Bending Left ___ Bending Right

___ Twisting Left ___ Twisting Right ___ Coughing ___ Sneezing ___ Straining ___ Standing

___Lifting ___Sitting ___ Heat ___ Ice ___ Rest ___ Lying Down ___ Medications

Pain Radiates to: *(Please check all that apply)*

___ Head ___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___ Leg ___ Foot

IF YOU HAVE MORE THAN 3 COMPLAINTS, LET THE FRONT DESK KNOW AND AN ADDITONAL SHEET WILL BE HANDED TO YOU.

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC

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

___ Alcohol/Drug Dependence	___ Recent Fever	___ Diabetes	___ High Blood Pressure
___ Stroke (Date: _____)	___ Cortison/Prednisone	___ Taking Birth Control	___ Dizziness/Fainting
___ Numbness in Groin/Buttocks	___Osteoporosis	___Epilepsy/Seizures	___ Prostate Problems
___ Menstrual Challenges	___ Cancer/Tumor	___ Urinary Problems	___ Frequent/Painful Urination
___ Loss of Bladder Control	___ Colitis	___ Irritable Colon	___ Constipation
___ Digestion Issues	___ Hearing Changes	___ Smelling Changes	___ Visual Disturbances
___ Heart Disease/Chest Pain	___ Rapid Heartbeat	___ Shortness of Breath	___ Heart Problems/Palpitations
___ Morning Pain/Stiffness	___ Pain at Night	___ Rheumatoid Arthritis	___ Pain unrelieved by position
___ Abnormal weight gain/loss	___ Currently Pregnant		

Surgical History: _____

Medications: *If you have more than 3, please attach or bring a list.*

_____

Allergies: _____

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 CHIROPRACTIC

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 without 24 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 CHIROPRACTIC

DR. ROBERT W RAMSEY, DC PC
575 NE 2nd Street - GRESHAM, OR 97030
Phone: 503-667-6744 Fax: 503-661-7896

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 CHIROPRACTIC

DR. ROBERT W RAMSEY, DC PC
575 NE 2nd - GRESHAM, OR 97030
Phone: 503-667-6744 Fax: 503-661-7896

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 _____

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC

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: _____ Signature: _____ Date:_____

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC

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

APPLICATION FOR CARE AT GRESHAM FAMILY CHIROPRACTIC
DR. ROBERT W. RAMSEY, D.C., P.C.
Gresham Family Chiropractic Clinic
575 NE 2nd Street, Gresham, OR 97030
Phone (503) 667-6744 / Fax (503) 661-7896

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Ilene Wilkens, Dr. Ramsey or Veronica Phelps

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.greshamchiropractor.net, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We do have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

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

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.
  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your

care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:* *http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf*

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Ilene Wilkens you may contact our Privacy Officer, or any staff member, including Robert Ramsey at the following phone number 503-667-6744 or our website www.greshamchiropractor.net for further information about the complaint process.

D. 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

This notice was published and becomes effective on December 1st, 2017