1001 South Whitney Way, Madison, WI 53711 • 608-274-6200

Patient History

Patient Information

Thank you for choosing Springtime Chiropractic for your chiropractic needs. Please complete this form (front and back). If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name ____ Date _____/_____/____ Social Security #: ________/_______/________

Address ____ City _____________________ State _____ Zip ____________

Responsible party (if patient is a minor) ____

Address ____

Sex: ☐F ☐M Birthdate _____/_____/_____ E-mail ____

Home Phone (_____)__________ Work Phone (_____)__________ ext: _____ Cell Phone (_____)__________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School ____ Occupation ______________________________

Employer/School Address ____

Person to contact in case of emergency ____ Phone (_____)__________

How did you hear about us? _____________ ____

Responsible Party/Insurance

<u>*Please present the receptionist with your insurance card(s so copies can be made for our records).*</u>

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work Comp ☐ Personal Injury Date _____/_____/_____

Insurance Company _______________________________________ Group # ___________________ ID# ___________________

Subscriber's Name _______________________________________ Birthdate _____/_____/_____ SS# ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No If <u>yes</u>, please complete the following information.

Insurance Company _______________________________________ Group # ___________________ ID# ___________________

Subscriber's Name _______________________________________ Birthdate _____/_____/_____ SS# ______________________

Assignment and Release

I certify that I and/or my dependants have insurance coverage through the above named company and assign directly to Dr. Jamie Lenz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Lenz may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ _________________________

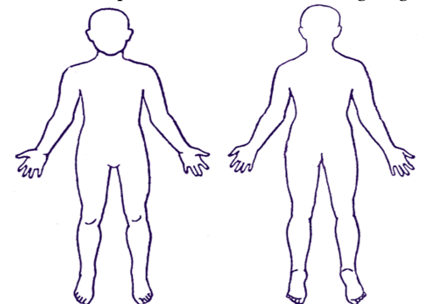
Patient Signature (Parent, if minor) Date

Patient Health History

Reason for this visit ____

Date condition started _____/_____/_____

*Mark an **X** on the picture where you continue to have pain, numbness, or tingling.*



Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). ____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______________________________

Is it **constant** or does it **come and go**? (circle one)

Does it interfere with your: ☐ Work ☐ Sleep ☐ School ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending

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Any other conditions? (Use "R" for Right and "L" for Left)

_____ Head	_____ Neck	_____ Legs	_____ Chest	_____ Mid-Back	_____ Low Back
_____ Arm	_____ Elbow	_____ Shoulder	_____ Hand	_____ Wrist	_____ Knees
_____ Ankles	_____ Feet	_____ Hips	_____ Abdomen		

Have you ever had any of the following conditions?

☐ Heart Attack	☐ Heart Surgery/Pacemaker	☐ Heart Murmur	☐ Congenital Heart Defect
☐ Mitral Valve Prolapse	☐ Artificial Valves	☐ HIV+/Aids	☐ Hepatitis
☐ Alcohol Abuse	☐ Drug Abuse	☐ Cancer	☐ Emphysema
☐ Glaucoma	☐ Anemia	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Psychiatric	☐ Rheumatic Fever	☐ Headaches	☐ Kidney Problems
☐ Ulcers	☐ Colitis	☐ Fainting	☐ Seizures/Epilepsy
☐ Sinus Problems	☐ Asthma	☐ Diabetes	☐ Tuberculosis
☐ Breathing Difficulty	☐ Chemotherapy	☐ Lower Back Problems	☐ Artificial Bones/Joints
☐ Arthritis	☐ Allergy	☐ Fatigue	☐ Female Disorders
☐ Depression	☐ Insomnia	☐ Vision Problems	☐ Neck Pain

List any condition you have been treated for in last 10 years ____

____

Are you taking any of the following medications?

☐ Pain Killers	☐ Nerve Pills	☐ Muscle Relaxers	☐ Stimulants
☐ Tranquilizers	☐ Blood Thinners	☐ Insulin	☐ Blood Pressure Medication
☐ Birth Control	☐ Antidepressants	☐ Others (specify) ____________________	

Have you had	YES	NO	If YES, date and briefly describe
Previous Chiropractic	☐	☐	______________________________
Operations/Surgery	☐	☐	______________________________
Fractured Bones	☐	☐	______________________________
Auto Accident	☐	☐	______________________________
Falls and/or Injuries	☐	☐	______________________________

For Women Only

Are you pregnant? ☐ Yes ☐ No Due Date? _____/_____/_____

Are you nursing? ☐ Yes ☐ No

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ____________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ____________

Family History: Any health problems of immediate family?

Mother ____

Father ____

Other *(include relationship)* ____

____ ______________________

Patient Signature (Parent, if minor) Date

CONSENT TO TREAT

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic treatment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the journal of the American Medical Association found that more than 2 million Americans become seriously ill each year from reactions to currently prescribed drugs. 106,000 of those people die from the side effects.

I understand the remote possibility of an injury to myself from a chiropractic treatment and elect to receive the recommended treatment.

Print Patient Name: ____

Signature:____ Date: ______________

Dr. Jamie Lenz, DC, CCSP, CACCP
• 1001 South Whitney Way, Madison, WI 53711 • (608) 274 – 6200 • Fax: (608) – 278 - 4586 •

AUTO ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name ____ Today's Date ____________

Date of Accident ____________________ Time of Accident __________________________ ☐ AM ☐ PM

Please describe the accident in your own words ____
____
____
____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian
How many people were in the accident vehicle (if applicable)? ______________
Have you retained an attorney? ☐Yes ☐ No If yes, whom? ___________________________

VEHICLE / ACCIDENT INFORMATION

Make and model of vehicle you were in? ____
Street/Road on which you were traveling?____
Which direction were you headed? ____
Approximate speed of the vehicle you were occupying? _________________________________

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder
Was vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did airbag(s) inflate? ☐ Yes ☐ No
Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest in relation to the base of your skull?
☐ Low ☐ Mid-Position ☐ High
Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
If yes, describe: ____

What did your vehicle impact? ☐ Another vehicle ☐ Other
If another vehicle, make of model of other vehicle ___________________________
Direction other vehicle was headed? __________________________________
Approximate speed of the other vehicle? _________
If other; explain: ____
Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other ________
During impact were you facing/looking: ☐ Right ☐ Left ☐ Forward ☐ Down ☐ Up
If driver, were both hands on the steering wheel? ☐ Yes ☐ No
If no, which hand was on the wheel? ☐ Left ☐ Right
Was your foot on the brake? ☐ Yes ☐ No
If yes, which foot was on the brake? ☐ Left ☐ Right

POLICE

Did the police come to the accident site? ☐ Yes ☐ No
Was a police report filed? ☐ Yes ☐ No
Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom? ____
Were there any witnesses? ☐ Yes ☐ No

Patient Name: DOB: DOI:

Springtime CHIROPRACTIC
Putting the spring back in your step.

Dr. Jamie Lenz, DC, CCSP, CACCP

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AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No
If yes, for how long? ____________________
Please describe how you felt immediately after the accident? ____________________
____
____

Have you gone to a hospital or seen any other doctor? ☐ Yes ☐ No
When did you go? ☐ Just after accident ☐ Next day ☐ 2 days plus
How did you get there? ☐Ambulance ☐ Private Transportation
Name of Hospital and/or Attending Doctor? ____________________
Was he/she a: ☐ DC ☐ MD ☐ DO ☐ DDS
Describe any treatment you received? ____________________
____

Were x-rays taken? ☐ Yes ☐ No
Was medication prescribed? ☐ Yes ☐ No
Have you been able to work since this injury? ☐ Yes ☐ No
Are your work activities restricted as a result of this injury? ☐ Yes ☐ No
Please indicate the symptoms that are a result of this accident:

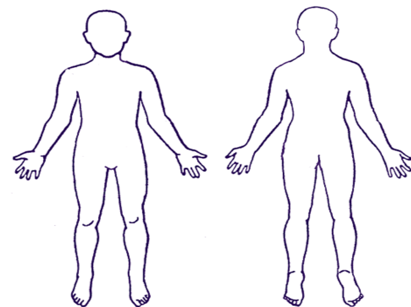
☐ Dizziness	☐ Difficulty sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/fingers	☐Lower back pain
☐ Blurred vision	☐ Tension	☐ Chest pain	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Shortness of breath	☐ Leg pain
☐ Ringing in ears	☐ Neck stiff	☐ Upset stomach	☐ Numb feet/toes

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable (even if only somtimes)	Painful		Comfortable	Uncomfortable (even if only somtimes)	Painful
Lying on back	☐	☐	☐	Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐	Sitting	☐	☐	☐
Standing	☐	☐	☐	Stretching	☐	☐	☐
Kneeling	☐	☐	☐	Lovemaking	☐	☐	☐
Reaching	☐	☐	☐	Walking	☐	☐	☐
Running	☐	☐	☐	Sports	☐	☐	☐
Standing	☐	☐	☐	Working	☐	☐	☐
Bending	☐	☐	☐	Lifting	☐	☐	☐

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following...

How many hours are in your normal work day? ____________

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Sitting	☐ Operating Equipment
☐ Twisting	☐ Walking	☐ Crawling	☐ Work with arms above head
☐ Typing	☐ Lifting	☐Bending	☐ Scooping

☐ Other: ____

What positions can you work in with minimum physical effort and for how long? ______________________

____ ☐ NA

Prior to the injury were you capable of working on an equal basis with others your age?	☐ Yes	☐ No	☐ NA
Do you work with others who can help you with any heavy lifting?	☐ Yes	☐ No	☐ NA
While in recovery is there any light duty work you could request?	☐ Yes	☐ No	☐ NA

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Neck Pain - Disability Index Questionnaire

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage *everyday* activities. Please answer each section by circling the **one choice** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please just circle the one choice which most closely describes your problem right now.**

SECTION 1 PAIN INTENSITY

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the very worst imaginable at the moment.

SECTION 2 PERSONAL CARE

A I can look after myself normally without causing extra pain.
B I can look after myself normally but is causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 LIFTING

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)
D Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 READING

A I can read as much as I want to with no pain in my neck.
B I can read as much I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 HEADACHES

A I have no headaches at all.
B I have slight headaches with come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 CONCENTRATION

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 WORK

A I can do as much work as I want to.
B I can do my usual work but no more.
C I can do most of my usual work but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 DRIVING

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 SLEEPING

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 sleepless).

SECTION 10 RECREATION

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all, of my recreational activities because of pain in my neck.
D I am able to engage in only a few of my recreational activities because of pain in my neck.
E I can hardly to any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Comments: ____

Patient Signature: ______________________________ Date: ______________

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Low Back Pain – Disabilty Index Questionnaire

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage everyday activities. Please answer each question by circling the **one choice** that most applies to you. We realize that you may feel that more than one statement may relate to you but **please just circle the one choice which most closely describes your problem right now**.

SECTION 1 — PAIN INTENSITY

A The pain comes and go and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is very moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 — PERSONAL CARE

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 — LIFTING

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)
E Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 — WALKING

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 — SITTING

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than 10 minutes.
F Pain prevents me from sitting at all.

SECTION 6 — STANDING

A I can stand as long as I want without pain.
B I have some pain while standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing because it increases the pain straight away.

SECTION 7 — SLEEPING

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal nights sleep is reduced by less than one quarter.
D Because of pain my normal nights sleep is reduced by less than one half.
E Because of pain my normal nights sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 — SOCIAL LIFE

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc).
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 — TRAVELING

A I get no pain while traveling.
B I get some pain while traveling but none of my usual forms of travel make it any worse.
C I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 — CHANGING DEGREE OF PAIN

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: ____

Patient Signature: ______________________________ Date: ______________

1001 South Whitney Way, Madison, WI 53711

PAYMENT POLICY

If your insurance policy provides for chiropractic services, this is our payment plan.

LIMITED ASSIGNEMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month. **Copays are due at time of service or a $10.00 surcharge will be added.**

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) If you require an appointment after hours, there is a $50.00 emergency charge that is not covered by your insurance company. Payment is expected at the time of service.

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Springtime Chiropractic. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid are considered delinquent. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of $27.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of $20.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

____ ______________________

Patient or Guardian Signature Date

DR. JAMIE LENZ, DC, CCSP, CACCP
1001 S WHITNEY WAY
MADISON WI 53711
(608) 274-6200

NOTICE OF PRIVACY PRACTICES (HIPPA)

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or facility if it is necessary to refer you to them for diagnosis, assessment, or treatment of your heath condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

10) We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Wisconsin's workers compensation laws.

Other than the circumstances described in the preceding examples, any other use of disclosure of your health information will only be made with your written authorization.

Marketing

Your Chiropractor and members of the practice staff may need to use your health information including your name, address, phone number and your clinical records for the purpose of marketing products and service to you. We are specifically requesting authorization to market the following products and/or services to you:

We may contact you by phone, mail, e-mail, fax, or other forms of electronic communication:
1) for appointment reminders and/or recall activities
2) with coupons for discounted services and/or products
3) announcing events, classes, or new products/services at our office

We may display inside our office:
1) pictures, cards, letters, drawings, artwork, recipes, jokes, testimonials, and/or things given to us by our patients or their families
2) acknowledgement of new patients, birthdays, anniversary's, and/or thank you for referrals.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:
1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or status of your account. We will do our best to accommodate any reasonable request if you would like receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Your request to inspect and/or copy your health information must be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1) Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2) Those disclosures made to you.
3) Those disclosures we are permitted to make without your consent or authorization as described above.
4) Those disclosures made based on an authorization you signed.
5) Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6) Those disclosures for national security or intelligence purposes.
7) Those disclosures made to correctional officers or law enforcement officers.
8) Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw of modify your request.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your 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 our privacy notice. If we make a change to the terms of our privacy agreement we will notify you in writing when you when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will take any action against you if you do so. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

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

Dr Jamie Lenz
1001 S Whitney Way Madison WI 53711
Ph: (608) 274-6200 Fax: (608) 278-4586

This notice is effective as of September 9, 2009. This notice will expire seven years after the date upon which the record was created.

______________________________ __________________________

Patient Name (Printed) Date

______________________________ __________________________

Patient (or Representative) Signature Authorized Provider Signature

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Description of personal representative’s authority to act for the patient