

Kaliko Chiropractic

(Please Print Clearly)

PATIENT INFO:

LAST Name: _____ First Name: _____ Middle initial: _____
DOB: _____ Gender: _____ SSN: _____
Weight: _____ Height: _____ Name Suffix: _____
Marital Status: _____ Employment Status: _____ Professional Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: Phone: _____ Work: _____ Work Ext.: _____
Cell Phone: _____ Fax: _____ **Email:** _____

EMPLOYMENT INFO:

Employer Name: _____ Employer Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT:

Contact Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____

OTHER INFO:

Patient ID - State / Drivers License / Passport #: _____
Referred by / Relationship: _____
Attorney Name / #: _____ Type of injury: () Personal () Auto () Workmen's Comp

PRIMARY INSURANCE:

Primary Insured if not self Full Name: _____ DOB: _____
Address if different: _____
Relationship to Insured (Spouse, Child, etc.) _____ Others on your Insurance: _____
Subscriber ID: _____ Group No: _____ Plan Name: _____ Effective Date: _____
Deductible: _____ Visit Co-payment: \$ _____ Number of visits Authorized: _____

SECONDARY INSURANCE:

Secondary Insured if not self Full Name: _____ DOB: _____
Address if different: _____
Relationship to Insured (Spouse, Child, etc.) _____ Others on your Insurance: _____
Subscriber ID: _____ Group No: _____ Plan Name: _____ Effective Date: _____
Deductible: _____ Visit Co-payment: \$ _____ Number of visits Authorized: _____

Kaliko Chiropractic

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and / or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, dislocations, strokes and sprains. I do not need or expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intended this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Signature Patient's Name or Name of Patient Representative

Relationship

Date

CONSENT TO TREATMENT OF MINOR

I (we) being the parents (s) of _____, a minor, the age of _____ years, do hereby consent, authorize and request Kaliko Chiropractic, Dr. Michael Kaliko, and whomever he may designate as his assistant to administer treatment as he / she so deems necessary on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications, which may result from treatment.

SIGNATURE ON FILE

I authorize use of this information on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for all my bills.

I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

I authorize that I am responsible for payment of an office visit on all missed appointments lacking a 24 – hour cancel notice.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me will be immediately due and payable. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I, the undersigned, affirm and declare that I have been advised by the Doctor's office that the bringing of a fraudulent claim is a crime punishable by imprisonment and / or fine, and that the Doctor's office will not treat and / or be part of such fraudulent claims. I hereby authorize the Doctor to examine and treat any condition as he / she deems appropriate through the use of Chiropractic Health Care. I give authority for all of these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-ray negatives will remain the property of this office. I also agree that I am responsible for all bills incurred at this office.

PAST HEALTH HISTORY

PLEASE CHECK OR DESCRIBE:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones
 Other: _____
 Major Accident or Falls: _____
 Hospitalization (Other Than Above): _____
 Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment, However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | | |

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- | | |
|---|---|
| <input type="checkbox"/> Difficult Chewing/Clicking Jaw | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Joint Pain/Stiffness |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Spinal Curvature |
| <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> Hip/knee | |
| <input type="checkbox"/> Ankle | |

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Kidney Stones/Infection

FEMALES ONLY:

When was your last period? _____
 Are you pregnant? Yes No Not Sure

NERVOUS SYSTEM

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GASTRO-INTESTINAL

- | | |
|--|---|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Black/Bloody Stool |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Liver Problems | |
| <input type="checkbox"/> Gall Bladder Problems | |
| <input type="checkbox"/> Weight Trouble | |
| <input type="checkbox"/> Abdominal Cramps | |

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Chills
- Fever
- Sweats
- Headaches
- _____

MALE / FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Lumps
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FAMILY HISTORY

The following members have a similar or same problem as I do: Mother
 Father
 Sister
 Brother
 Spouse
 Child

NAME _____ **DATE** _____

CURRENT HEALTH CONDITION

Current Condition _____

Other Doctor's Seen For This Condition Yes No; Who? _____

Type of Treatment: _____

Results: _____

Date of Injury: _____ Time of Injury: _____ Has This Condition Occurred Before? Yes No

Is This Condition Job Related? Yes No Did You Make A Report of The Accident To Your Employer: Yes No

Is Condition: Auto Accident Fall Gym Home Injury Sports

Medications You Now Take: Pain Killers Muscle Relaxers Blood Pressure Insulin

Others _____

Do You Wear A Shoe Lift? Yes No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

1. Check only ONE body location below

- Headaches L R B
 Front of Head
 Top of Head
 Back of Head

- Jaw L R B
 Eye L R B
 Neck L R B
 Upper Back L R B
 Mid Back L R B
 Low Back L R B
 Chest L R B
 Abdomen L R B
 Ribs L R B
 Buttocks L R B
 Shoulder L R B
 Forearm L R B
 Hand L R B
 Hip L R B
 Leg L R B
 Foot L R B

Other locations: _____

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

2. Types of pain

- Dull Sharp Aching Cutting
 Throbbing Burning Numbing Tingling Cramping _____
 Spasm Stinging Shooting Pounding Constricting

3. Pain Frequency

- Up to 1/4 of awake time 1/4 to 1/2 of time
 1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects daily activities)

- Doesn't affect Somewhat affects
 Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of Radiation: _____

Other types of pain:

- _____
- Cramping _____
 Constricting

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other Actions:

- _____
- _____

1. Check only ONE body location below

- Headaches L R B
 Front of Head
 Top of Head
 Back of Head

- Jaw L R B
 Eye L R B
 Neck L R B
 Upper Back L R B
 Mid Back L R B
 Low Back L R B
 Chest L R B
 Abdomen L R B
 Ribs L R B
 Buttocks L R B
 Shoulder L R B
 Forearm L R B
 Hand L R B
 Hip L R B
 Leg L R B
 Foot L R B

Other locations: _____

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

2. Types of pain

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5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of Radiation: _____

Other types of pain:

- _____
- Cramping _____
 Constricting

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other Actions:

- _____
- _____

Name: _____

Date: _____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below.
Use the following 1 to 5 scale.

WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty:

- 1** = "I can do it without any difficulty"
- 2** = "I can do it without much difficulty, despite some pain"
- 3** = "I manage to do it by myself, despite marked pain"
- 4** = "I manage to do it, despite the pain, but only if I have help"
- 5** = "I cannot do it all, because of the pain"

Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
Showering____ Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____
Washing hair____ Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

Standing____ Walking____ Kneeling____ Bending back____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____ Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling

Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below :

- 1** = "This area is not affected by my condition"
- 2** = "This area is slightly affected by my condition"
- 3** = "My condition moderately restricts my ability in this area"
- 4** = " My condition seriously limits my ability in this area"
- 5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

**Write in below any additional information regarding your Activities of Daily Living
(that wasn't covered above):**

NAME _____ **DATE** _____

KALIKO CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

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.

Kaliko Chiropractic required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes.

Change of Ownership.

In the event that *Kaliko Chiropractic* is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, *Kaliko Chiropractic* that is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that *Kaliko Chiropractic* amend your protected health information. Please be advised, however, that *Kaliko Chiropractic* is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by *Kaliko Chiropractic*.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Kaliko Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, *Kaliko Chiropractic* is required by law to comply with this Notice.

Kaliko Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: *Judy Strohfeldt* by calling this office at (310) 855-9899. If Ms. Strohfeldt is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how *Kaliko Chiropractic* has handled your health information should be directed to *Judy Strohfeldt* by calling this office at (310) 855-9899. If Ms. Strohfeldt is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

**DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201**

This notice is effective as of ____/____/____. I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide *Kaliko Chiropractic* with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ Patient's Name (print)

_____ Patient's Signature _____ Date

_____ Authorized Facility Signature _____ Date