Kaliko Chiropractic

(Please Print Clearly)

PATIENT INFO:

LAST Name: _____First Name: _____Middle nitial:_____

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.

_____	_____	_____
Print Patient's Name or Name of Patient Representative	Relationship	Date
_____	_____	_____
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 of Parent or Guardian	*Signature* of Witness	Date

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.

_____	_____	_____
Print Name	*Signature*	Date

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.

_____	_____
Signature of Patient, Parent or Guardian authorizing care	Date

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:

☐ Pneumonia
☐ Rheumatic Fever
☐ Asthma
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Eczema

INTAKE
☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWINGYOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL
☐ Difficult Chewing/Clicking Jaw
☐ Neck Pain
☐ Pain Between Shoulders
☐ Arm Pain
☐ Lower Back Pain
☐ Sciatica
☐ Hip/knee
☐ Ankle
☐ Foot
☐ Walking Problems
☐ Joint Pain/Stiffness
☐ Poor Posture
☐ Spinal Curvature

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
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

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

Other types of pain:
_____
_____

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
❑Head	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of Radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
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

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

Other types of pain:
_____
_____

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
❑Head	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of Radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Name:_____ **Date:**_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type
❑Car ❑Station Wagon
❑Van❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle
❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?
❑Stopped at intersection ❑Stopped in traffic ❑Stopped at light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage
Time of accident_____
Your vehicle's
speed: _____mph
Their vehicle's
speed: _____mph
Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident
Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object)
_____

6. Road conditions
Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Read-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑ ❑No**
Were you braced for the impact? **Yes❑ ❑No**
Did you have a seat belt on? **Yes❑ ❑No**
Was your shoulder harness on? **Yes❑ ❑No**
Did driver side airbag deploy? **Yes❑ ❑No**

Does your vehicle have headrests? Yes❑❑No
What was the position of your headrest at the time of the impact?
❑Even with top of head ❑Even with bottom of head ❑Middle of neck
What was the direction of your head at the time of the impact?
❑Facing straight forward ❑Turned to the right ❑Turned to the left
Did passenger side airbag deploy? **Yes❑ ❑No** Side airbags? **Yes❑ ❑No**

8. Additional accident information
In the case of a motor vehicle accident, enter any additional information here that is not covered by the above.

9. During the accident:
Did your body strike inside of your vehicle? **Yes❑❑No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑❑No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑Mild ❑Moderate ❑Totaled
Did police show up at the scene? **Yes❑ ❑No**
Was an accident report filled out? **Yes❑ ❑No**

10. After the accident:
Check off your symptoms following the accident:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑Confusion	❑Nervousness	❑Diarrhea
❑Fainting	❑Fatigue	❑Loss of taste	❑Depression
❑Ringing in ears	❑Tension	❑Toe numbness	❑Anxious
❑Loss of smell	❑Irritability	❑Constipation	❑Chest Pain
❑Pain behind eyes	❑Shortness of breath	❑Sleeping problems	

Others:_____

11. Emergency Room?
Where did you go after the accident?
❑Home❑Work ❑Hospital ER❑Private Doctor
How did you get there?
❑Self ❑Somebody else ❑Ambulance. ❑Police
X-rays done? Yes❑ ❑No Lab work? Yes❑ ❑No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑Cervical Collar❑Ice **Other:**_____
Medications:_____
Follow-up instructions: _____ ____
_____

12. Treatment History:
Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑ ❑No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑ ❑No**
Did treatments benefit you? **Yes❑ ❑No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑ ❑No**
Did treatments benefit you? **Yes❑ ❑No**
Last visit date: ____/____/____

NAME_____**DATE**_____

Dominant Hand: ❑Right ❑Left ❑Both

1. Description of Accident / Injury / Onset *

Enter a full description of the accident, injury or onset in the space below.

**** If this is an automobile accident*, you can go to the next page. If you would like to describe it more fully, use the boxes above and below to fully describe your accident, injury or onset.**

2. During and after accident details

Enter the details of your condition during and after the accident/onset.

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