# Peterson Clinic

**1002 W Elm Hermiston, OR 97838**
**PO Box 211**
**541-567-6277 (Fax) 541-567-9055**
**www.petersonclinic.com**


**Date of Appointment:** ____________________ **Time** ____________________

Name ________________________________ Nickname ____________
First M Last

DOB ____________________ Sex: M or F

Home/Cell Phone ________________________ Work Phone ____________

Address ______________________________________________

City ____________________ State _____ Zip Code ________

Email address ___________________________

Do you give us permission to send notifications/statements to your email Y N

Occupation ____________________ Employer ____________________

Emergency contact: ____________________ Relationship: ________

Phone Number: ____________________

Relationship status: single married divorced dependent widowed

Spouse/Significant other: ____________________ Phone ______________

Friend/Relative not living with you: ____________________ Phone _______

Children? Y N if yes Number ________ Ages if under 21 ____________

Race (circle) : Black – Non Hispanic , American Indian/ Alaskan Native, Hispanic, Asian/Pacific Islander, White – Non Hispanic
Ethnicity: Hispanic Non Hispanic Not specified
Preferred language: English Spanish Other ________

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P.O. Box 211 • 1002 W. Elm • Hermiston, Oregon 97838

Peterson Clinic

Caring for the Whole Person...Naturally!

Since 1953

# Appointment Policy

Effective 08-20-2018,

1) **NEW PATIENTS APPOINTMENTS:**
A deposit of $150.00, will be required to schedule all New Patient appointments. This deposit will be collected at the time the appointment is scheduled. The fee will be applied towards the cost of the first visit. *The fee is fully refundable with a* ***24 hour*** *cancellation notice.*

2) **FOLLOW-UP VISITS**: All follow-up appointments *not cancelled within 4 hours of the appointment time,* will be charged the full cost of that appointment.

Kristopher B. Peterson, DC, DABCI, BCN, FICT, *Chiropractic Internist*

Trent J. Teegarden, DC, *Chiropractic Physician*
Anton L. Alder, ND, *Naturopathic Physician*

Name: ______________________________ DOB: ____________ Date: ___________

**Primary complaint**: ______________________________________________

Date of onset: ____________________________ (please circle) Gradual or Sudden onset

Is condition: (circle all that apply) stable worsening variable

If you have sought other care please circle all that apply: If none apply leave blank

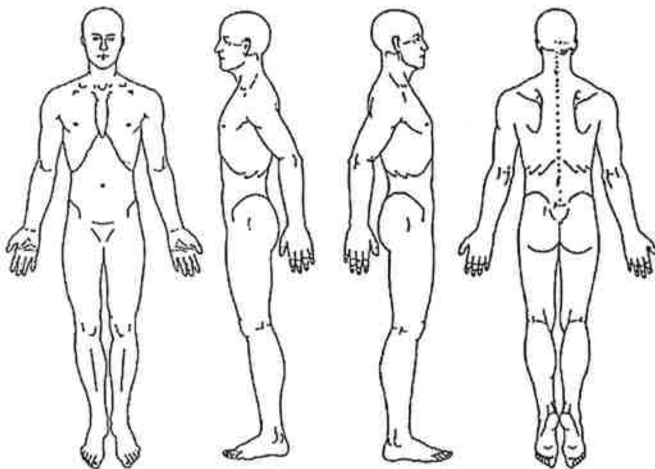
| | | | | |
|---|---|---|---|---|
| Chiropractic | o Improved | o No Change | o Worse | Comment |
| MD/DO/NP/PA | o Improved | o No Change | o Worse | |
| Naturopathic | o Improved | o No Change | o Worse | |
| PT | o Improved | o No Change | o Worse | |
| Massage Therapy | o Improved | o No Change | o Worse | |
| Acupuncture | o Improved | o No Change | o Worse | |
| Nutritional | o Improved | o No Change | o Worse | |
| Surgery | o Improved | o No Change | o Worse | |
| Exercise | o Improved | o No Change | o Worse | |
| Counseling | o Improved | o No Change | o Worse | |
| Prescriptions | o Improved | o No Change | o Worse | |
| Diet | o Improved | o No Change | o Worse | |

Please rate your pain/discomfort:

NO PAIN

WORST POSSIBLE PAIN

Please indicate on the figure below if there is any pain, numbness, tingling or discomfort



Additional Information: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

Name: ______________________________ DOB: ____________ Date: ___________

**Secondary complaint**: ________________________________________

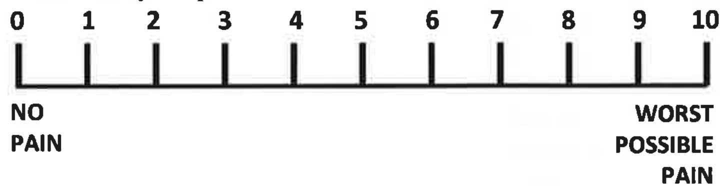
Date of onset: ______________________________ (please circle) Gradual or Sudden onset

Is condition: (circle all that apply) stable worsening variable

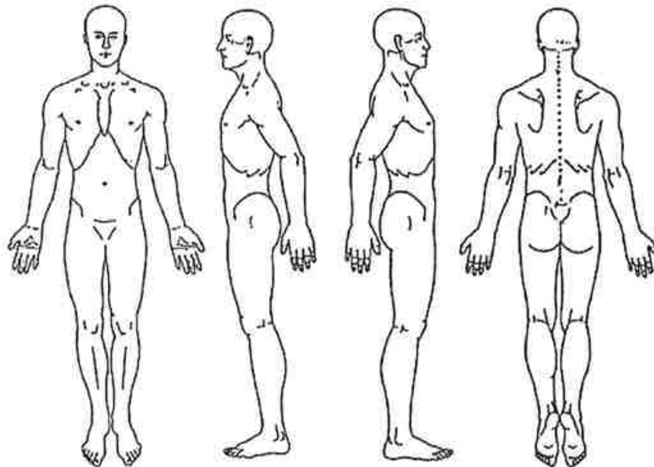
If you have sought other care please circle all that apply: If none apply leave blank

| Chiropractic | o Improved | o No Change | o Worse | Comment |
|---|---|---|---|---|
| MD/DO/NP/PA | o Improved | o No Change | o Worse | |
| Naturopathic | o Improved | o No Change | o Worse | |
| PT | o Improved | o No Change | o Worse | |
| Massage Therapy | o Improved | o No Change | o Worse | |
| Acupuncture | o Improved | o No Change | o Worse | |
| Nutritional | o Improved | o No Change | o Worse | |
| Surgery | o Improved | o No Change | o Worse | |
| Exercise | o Improved | o No Change | o Worse | |
| Counseling | o Improved | o No Change | o Worse | |
| Prescriptions | o Improved | o No Change | o Worse | |
| Diet | o Improved | o No Change | o Worse | |

Please rate your pain/discomfort:




Please indicate on the figure below if there is any pain, numbness, tingling or discomfort



Additional Information: ________________________________________

________________________________________

________________________________________

________________________________________

Name: ______________________________ DOB: ____________ Date: ___________

## If complaint is due to an injury related to work or auto accident please inform staff for special forms.

Right handed or Left handed (circle)
Blood Type (circle): A B AB O Unknown

**Body Systems Check** – Circle your **current** problems:
**Current** – *Weight* __________ *Height* ____________
**Sleep** – Problems falling asleep / Freq. waking / Early waking / Wake un-refreshed / Sleepy / Night sweats
**General** – General run down feeling / Frequent colds/flu / Nausea / Swelling / Swollen glands
**Head** – Headaches / Migraines / Scalp issues / Hair loss
**Eyes** – Blurred vision / Itchiness / Spots / Dryness / Glaucoma / Photosensitivity
**Ears** – Hearing difficulty / Infections / Itchy ears / Sound sensitivity / Wax build up / Ringing
**Sinuses** – Sinusitis / Congestion / Dripping / Phlegm / Allergies
**Lungs & Heart** – Breathing difficulty / Infections / Palpitations / Chest pain/Angina / Arrhythmias / Blood pressure
**Muscle & Joints** – Pain / Inflammation / Back/Neck/Shoulder / Lack of mobility / Muscle weakness / Fibromyalgia / Arthritis
**Nerves** – Pain / Burning / Numbness / Tingling / Sensitivity / Dizziness / Concussion or blow to head
**Bladder** – Pain / Frequent night visits to toilet / Infections / Stress Incontinence (urine dribbles)
**How often do you pass stools? Times per day** ____________
**Stools tend to be:** Loose / Formed / Constipated / Alternating / Blood / Discolored stool
**Digestion** – Abdominal pain / Gastric reflux / Difficulty swallowing / Food cravings / Bloating
**Skin** – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot / Moles / Weak nails
**Cognitive** – Poor concentration / Memory / Comprehension / Disorientation
**Mood** – Depression / Anxiety / Irritable / Panic attacks / PTSD / ADHD
Other: ______________________________________________
______________________________________________

**Your Past Medical History**

**Check those questions to which your answer is yes (leave others blank)**

- ❒ Heart attack; if so, how many years ago?
- ❒ Stroke
- ❒ Heart murmur
- ❒ Diseases of the arteries
- ❒ Varicose veins
- ❒ Arthritis of legs or arms
- ❒ Diabetes or abnormal blood sugar tests
- ❒ Cancer
- ❒ Phlebitis (inflammation of a vein)
- ❒ Dizziness or fainting spells
- ❒ Epilepsy or seizures
- ❒ Concussion/TBI
- ❒ Auto accident, sports injury, work injury, other major injuries____________
- ❒ Memory problems
- ❒ Anxiety / depression / mood disorder

Name: ______________________ DOB: ____________ Date: ____________

*Continued personal history*

- ❐ Anemia
- ❐ Thyroid problems
- ❐ Pneumonia/Bronchitis
- ❐ Asthma
- ❐ Abnormal chest X-ray
- ❐ Other lung disease
- ❐ Broken bones
- ❐ Jaundice or gallbladder problems
- ❐ Kidney disease
- ❐ Auto-immune disease

**Comments:** ______________________________________________

______________________________________________

***Family History** (Check all that apply, if deceased please state cause of death)

| | Status | Age | Cancer | Heart Attack / Stroke | Auto-Immune | Tremor/ Shaky | Memory Loss | Diabetes | Depression/anxiety, ADHD, OCD/ Addiction, etc. |
|---|---|---|---|---|---|---|---|---|---|
| Father | alive/deceased | | | | | | | | |
| Mother | alive/deceased | | | | | | | | |
| Brother | alive/deceased | | | | | | | | |
| Sister | alive/deceased | | | | | | | | |
| Son | alive/deceased | | | | | | | | |
| Daughter | alive/deceased | | | | | | | | |

**Additional comment:** ______________________________________________

______________________________________________

**Familial Diseases**

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half relatives)?

Check those to which the answer is yes (leave others blank)

- ❐ Heart attacks under age 50
- ❐ Strokes under age 50
- ❐ Arthritis
- ❐ High blood pressure
- ❐ Elevated cholesterol
- ❐ Diabetes
- ❐ Asthma or hay fever
- ❐
- ❐ Congenital heart disease (existing at birth but not hereditary)
- ❐ Heart operations
- ❐ Glaucoma
- ❐ Obesity (20 or more pounds overweight)
- ❐ Leukemia or cancer under age 60
- ❐ Mental illness
- ❐ Neurological disease: MS Parkinson's ALS Essential tremors
- ❐ Celiac disease

Name: ______________________________ DOB: ___________ Date: __________

| Please list ALL surgeries | Year of Surgery |
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| Please list any allergies to food, medication and other factors |
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**LIFESTYLE HABITS**

Main interests and hobbies? ____________________

Exercise, what kind? ________________________

How often do you exercise? ____________________

Y N Have a religious/spiritual practice

Y N Average 6-8 hours of sleep

Y N Have a supportive relationship

Y N History of abuse — If yes, Physical Verbal Sexual

Y N Major traumas — Please list date and type ______________________

Y N Use recreational drugs

Y N Treated for drug dependence

Y N Drink coffee — If yes, how many cups _______ per day / per week

Y N Drink black or green tea — If yes, how many cups _______ per day / per week

Y N Drink cola or other sodas — If yes, how many ounces _______ per day / per week

Y N Add salt to your food

Y N Eat refined sugar — If yes, circle all that apply: pastries sodas candies ice cream others___

Y N Enjoy your work

Y N Take vacations

Y N Spend time outside — Hours per week __________

Y N Watch TV? — How much? ____________

Y N Read? — How often? ____________

Y N Use alcoholic beverages — # of drinks/week ___________

Y N Treated for alcoholism

Y N Use tobacco currently — How many years? ________ How many packs/day ______

Y N Used tobacco in the past — What year did you quit? ________

Name: ______________________________________ DOB: ______________ Date: ____________

| Current medications | Dosage and why do you take? |
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| Current supplements | Dosage and why do you take? |
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# Insurance Information

**Please call your Insurance company for any information that you do not know! YOUR ACCOUNT WILL BE CASH UNTIL ALL REQUIRED INFORMATION IS PROVIDED. A super bill will be provided**

Patient's Name________________________________

Relationship to insured: Self Child Spouse
Insured's Name if not Patient____________________________________________
Insured's Social Security #_______________ Insured's DOB__________________

Insured's address, if different from patient: ___________________________________

City_______________ St_____ Zip__________ Phone #______________________

Insurance Co. Name____________________________________________________
Policy #________________________ Group #___________________________

Chiropractic Coverage? Y N If yes, is there a deductible: $_________________
Naturopathic Coverage? Y N If yes, is there a deductible: $_________________
Has it been met for this year? Y N When does plan year start?__________________

Is there a co-pay? Y N Co-pay amount $__________. If no copay, what percent does plan pay?
**80/20%, 85/15% 70/30%, 60/40%, 50/50%,** Or other______%

Is there a limit on care? Y N If yes, maximum payment amount per year $_________
OR Max number of visits per plan year ____________

Is this per family member? Y N Is this total for the whole family? Y N

Dr Kris & Dr. Trent are PPO's (in Network) for BCBS AND ODS/MODA,

Do you have **Non-PPO (Out of Network)** coverage? Y N If yes what is copay _____
Or percent coverage?_______________

ADDITIONAL OPTIONAL INFORMATION
Does insurance pay for diagnosis other than musculoskeletal? Y N

Does your policy cover diagnostic testing ordered by a chiropractic physician? Y N
Does your policy cover diagnostic testing ordered by a naturopathic physician? Y N
X-ray Diagnostic Ultrasound MRI/CT EKG QEEG Blood work
Neurofeedback/Biofeedback 90901 or 95812 for what diagnosis do they pay?_________

I authorize Peterson Clinic to receive payments directly from my insurer.

Signed:___________________________________ Date____________________

Name: ______________________ DOB: ______________ Date: ______________


# Peterson Clinic

## 1002 W Elm Hermiston, OR 97838

## PO Box 211

**541-567-6277 (Fax) 541-567-9055**

www.petersonclinic.com


OFFICE POLICIES

1) Cancellation
   a. Except for an emergency, missed appointments will be charged ½ of the fee if not cancelled within 4 hours of the visit.
   b. Except for an emergency, new patient visits need to be cancelled 24 hours before the visit to have the visit payment refunded.
2) Medicare
   a. Medicare will only pay for Chiropractic spinal manipulation related to acute injury of the spine that is expected to improve. They do NOT pay for examinations, supplements, maintenance/pain care or services ordered.
3) Private Insurance
   a. If you have private insurance, please notify the staff for the appropriate form and information required.
4) For services rendered to the patient named above, I the undersigned agree to pay all professional charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.
5) Informed consent:
   a. I (or the patient for whom I am legally responsible for) give the doctor permission to examine me.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote, about the same risk as seeing a medical provider.

b. I understand that evaluation, diagnosis and treatment by a naturopathic physician may include, but is not limited to: history taking, physical examination, common diagnostic procedures (including diagnostic imaging and lab work), dietary/nutritional advice, botanical medicines and nutraceuticals, homeopathic remedies, over the counter or prescription medications, naturopathic manipulation or physical medicine, hydrotherapy, and/or counseling. I understand that it is my responsibility to inform my doctor if I am pregnant, breast-feeding, or suspect that I may be pregnant. I have been informed that while naturopathic medicine is generally considered a safe method of treatment that I may experience pain, discomfort, minor bruising, aggravations of pre-existing conditions, allergies, and other unforeseen side effects. I understand that the health benefits are thought to be greater than any risk associated with treatment and my doctor will take every precaution to avoid adverse effects.

I acknowledge that I have read and filled out this form.

Signature ______________________________ (patient or parent/legal guardian)
If not completed by patient: Person filling out form ______________________
Relationship to patient: ______________________________ Date: ______________

# PETERSON CLINIC
# 1002 W Elm
# Hermiston, OR 97838
# 541-567-6277

**Notice of Privacy Practices**

Effective May 1, 2014

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

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is obligated to notify you promptly if a breach occurs that may have compromised the privacy and security of your PHI. The Practice is also required by law to abide by the terms of this Notice.

## HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

**For Treatment** – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, health students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

**For Payment** – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you

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for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

**For Health Care Operations** – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

## OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

**Appointment Reminders** -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

**Individuals Involved in Your Care or Payment for Your Care** – We may disclose to a family member, other relative, a close friend, or any other person identified by you certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

**Disaster Relief -** We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

**De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

**Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

**Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

**Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

**Public Health and Safety Activities** – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability

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- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Victims of Abuse, Neglect or Domestic Violence** – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

**Health Oversight Activities** – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

**Judicial and Administrative Proceedings** – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

**Disclosures for Law Enforcement Purposes** – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

**To Avert Serious Threat to Health or Safety** – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

**Coroners, Medical Examiners and Funeral Directors** – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

**Organ, Eye or Tissue Donation** – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

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**Workers Compensation** – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

**Special Government Functions** – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

**Research** – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

**Fundraising** – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

## AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

**Marketing Purposes** – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

**Sale of Health Information** – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

## YOUR RIGHTS

**Right to Revoke Authorization** – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

**Right to Request Restrictions** – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket, and we will abide by that request unless we are legally obligated to do otherwise.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must provide your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both, and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

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**Right to Receive Confidential Communications** – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

**Right to Inspect and Copy** – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

**Right to Amend** – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

**Right to an Accounting of Disclosures** – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

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**Right to a Paper Copy of this Notice** – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

**Right to File a Complaint** – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Kristopher B Peterson, DC**

Address: **1002 W Elm, Hermiston, OR 97838**

Telephone No.: **541-567-6277**

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