Young Chiropractic
& Acupuncture

2911 Crossing Court Suite 101
Champaign IL,61822
(217) 359-0550
www.young-chiro.com

Your Health Profile

Personal Information

NAME: AGE: TODAY'S DATE:

ADDRESS:

CITY / STATE / ZIP:

HOME #: CELL #: WORK #:

EMAIL ADDRESS:

BIRTHDATE: SINGLE: MARRIED: DIVORCED: WIDOWED:

OCCUPATION:

EMPLOYER'S NAME & ADDRESS:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

PREFERRED LANGUAGE:

RACE (CIRCLE ONE): AMERICAN INDIAN OR ALASKA NATIVE/ ASIAN /BLACK OR AFRICAN AMERICAN

WHITE OR CAUCASIAN/ NATIVE HAWAIIAN OR PACIFIC ISLANDER/ I DECLINE TO ANSWER

ETHNICITY(CIRCLE ONE): HISPANIC OR LATINO/ NOT HISPANIC OR LATINO/ I DECLINE TO ANSWER

Your Main Concern(s)

Is today's visit related to an active Work Compensation case? Yes No

Is today's visit related to a current Personal Injury case? Yes No

Briefly explain why you came to our office: _____

List your health concerns and/or any symptoms:	Rate of Severity 1 = mild 10 = worst	Are symptoms constant or intermittent?	If you have pain, please describe it: (dull, sharp, etc.)	When did this episode begin?
1. _____	____	_____	_____	_____
2. _____	____	_____	_____	_____
3. _____	____	_____	_____	_____

Would you like to be informed of what nutritional supplements may help address your current health concerns or symptoms? Yes No

If there is a need for specific exercises, would you like to be informed? Yes No

Please list other practitioners or doctors seen for this condition:

Name	Location	Date Seen	Diagnosis	What was done?

Please list name and facility of your primary care physician:_____

_____

Have you been diagnosed with a medical condition or illness (please explain any and all)? _____

_____

Have you ever seen a chiropractor? _____ If yes, what was your experience like? _____

_____

Non-Pregnancy Verification (skip if you are not female)

Are you pregnant? Yes / No

Date of last menstrual period:_____

By my signature on this form I do hereby state, that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient Signature:_____

Witness:_____

Have you had any surgeries? **YES / NO**

1. Type: _____ Year: _____
2. Type: _____ Year: _____
3. Type: _____ Year: _____

Have you had any accidents, injuries or traumas from birth to present? (falls, auto, work-related, etc.) **YES / NO**

1. Type: _____ Year: _____
2. Type: _____ Year: _____
3. Type: _____ Year: _____

Do you have any medication or supplement allergies? **YES / NO**

Medication Name	Reaction	Onset Date	Additional Comments

Smoking Status **(Circle One)**: Every Day Smoker/ Occasional Smoker/Former Smoker/ Never Smoked

Start Date:_____ Quit Date:_____

Are you currently taking any medications, over the counter medications, or supplements? **YES / NO**

Medication Name	Dosage and Frequency (i.e. 5 mg once a day, etc.)

Please mark all symptoms you have experienced in the past four (4) months, even if they are not related to your current problem:

☐ headaches	☐ pins and needles in legs	☐ fainting
☐ loss of smell	☐ loss of balance	☐ dizziness
☐ ringing in ears	☐ nervousness	☐ loss of taste
☐ numbness in fingers	☐ numbness in toes	☐ fatigue
☐ sleeping problems	☐ stiff neck	☐ cold feet & hands
☐ fever	☐ hot flashes	☐ lights bother eyes

Diabetes:

- Do you have diabetes? ☐ Yes ☐ No If so, are you under the care of a physician? ☐ Yes ☐ No

If so, what type?
- ☐ Type I- Insulin dependent (insulin injections only)
- ☐ Type II- Non-insulin dependent (diabetic pills)
- ☐ Type II- Insulin dependent (diabetic pills and insulin)

Do you or a member of your immediate family have or had any of the following? (Immediate family: Father, Mother, Brothers, Sisters) Respond to every item. For items marked "Y" make comments below.

	You		Family				You		Family		
	Y	N	Y	N	Relationship		Y	N	Y	N	Relationship
Blood Pressure						Irregular Periods					
Multiple Sclerosis						Menopause					
Cancer						Anorexia (or history of)					
Liver Problems						Rheumatoid Arthritis					
Irritable Bowels						Epilepsy					
Crohn's Disease						Thyroid Problems					
Acid Reflux						Gout					
Diverticulosis						Heart Disease					
Kidney Disease						Bulimia (or history of)					
Depression						Gastric Ulcer					
Heartburn						Celiac Disease					

Comments:

_____

_____

I HEREBY AUTHORIZE YOUNG CHIROPRACTIC TO SHARE:

Any of my medical information, **including information about**:
___ My lab results
___ My appointment times, dates, and reasons for the visits
___ The medications I am taking
___ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to Young Chiropractic & Acupuncture), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical/dental provider or my clinic to share my information with someone.
This authorization expires: _____When I cancel it in writing or on _____
Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian):* _____ *If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)*

Witness: _____ Date: _____

Emergency Contact Info

Name: _____

Address: _____

City/State/Zip: _____

Relationship: _____

Cell/Home/Work #: _____

For office use only.

Height _____ Weight_____ BP ____/____

Current Pain Complaints

Name: _____ Today's Date: _____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing. Include **ALL** affected areas.

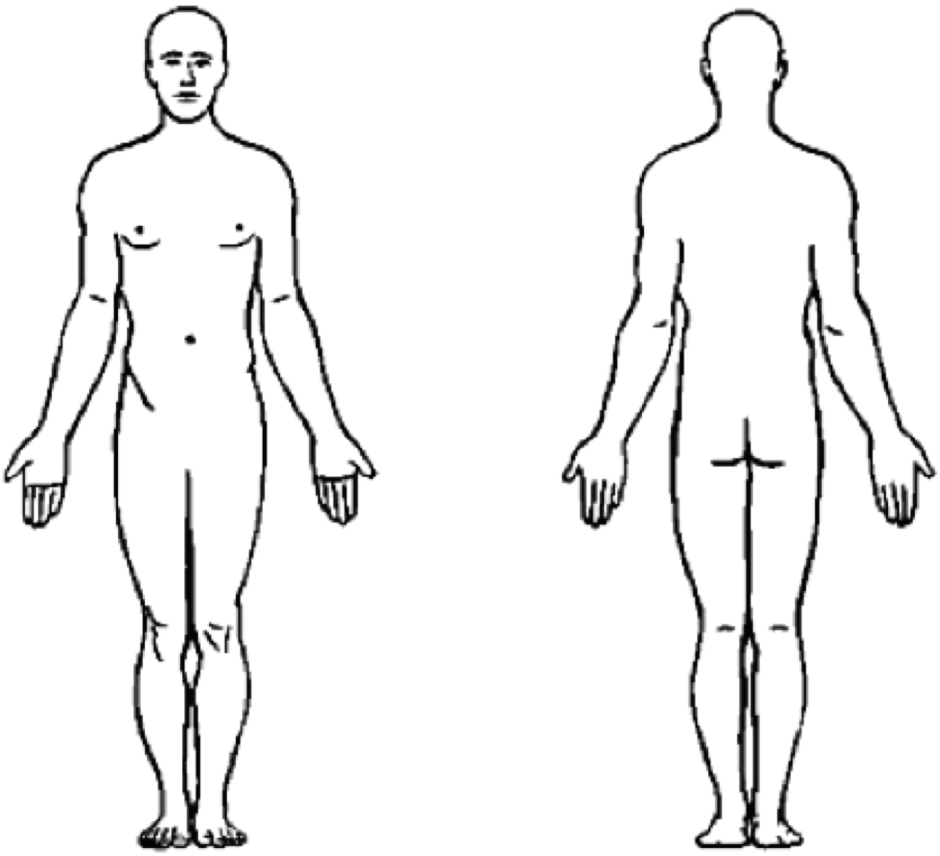
Sharp & Stabbing = ++++++

Dull & Achy = vvvvvv

Pins & Needles = oooooo

Numbness = //////

Weakness = ΔΔΔΔΔ



Please indicate severity of pain by placing an "X" on the graph(s) below. Also, please indicate the area, for example "low back," on the line to the left of the graph.

Area #1: _____

No Pain Moderate Pain Unbearable Pain

Area #2: _____

No Pain Moderate Pain Unbearable Pain

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NAME: _____ DATE: _____

VERNON MOIR NECK PAIN DISABILITY INDEX QUESTIONNAIRE ***PLEASE CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity

- **I have no pain at the moment.**
- **The pain is very mild at the moment.**
- **The pain is moderate at the moment.**
- **The pain is fairly severe at the moment.**
- **The pain is very severe at the moment.**
- **The pain is the worst imaginable at the moment.**

SECTION 2 -Personal Care (Washing, Dressing, etc.)

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

SECTION 3 - Lifting

- **I can lift heavy weights without extra pain. I can lift heavy weights, but it gives extra pain.**
- **Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.**
- **Pain prevents me from lifting heavy weights, but I can manage**
- **light to medium weights if they are conveniently positioned.**
- **I can lift very light weights.**
- **I cannot lift or carry anything at all.**

SECTION 4 - Reading

- **I can read as much as I want to with no pain in my neck.**
- **I can read as much as I want to with slight pain in my neck.**
- **I can read as much as I want to with moderate pain in my neck.**
- **I can't read as much as I want because of moderate pain in my neck.**
- **I can't read as much as I want because of severe pain in my neck.**
- **I cannot read at all.**

SECTION 5 - Headaches

- **I have no headaches at all.**
- **I have slight headaches which come infrequently.**
- **I have moderate headaches which come infrequently.**
- **I have moderate headaches which come frequently.**
- **I have severe headaches which come frequently.**
- **I have headaches almost all the time**

SECTION 6 - Concentration

- **I can concentrate fully when I want to with no difficulty.**
- **I can concentrate fully when I want to with slight difficulty.**
- **I have a fair degree of difficulty in concentrating when I want to.**
- **I have a lot of difficulty in concentrating when I want to.**
- **I have a great deal of difficulty in concentrating when I want to.**
- **I cannot concentrate at all.**

SECTION 7 - Work

- **I can do as much work as I want to.**
- **I can only do my usual work, but no more.**
- **I can do most of my usual work, but no more.**
- **I cannot do my usual work.**
- **I can hardly do any work at all.**
- **I cannot do any work at all.**

SECTION 8 - Driving

- **I can drive my car without any neck pain.**
- **I can drive as long as I want with slight pain in my neck.**
- **I can drive as long as I want with moderate pain in my neck.**
- **I can't drive as long as I want because of moderate pain in my neck.**
- **I can hardly drive at all because of severe pain in my neck.**
- **I cannot drive my car at all.**

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

- **I am able to engage in all of my recreational activities with no neck pain at all.**
- **I am able to engage in all of my recreational activities with some pain in my neck.**
- **I am able to engage in most, but not all of my recreational activities because of pain in my neck.**
- **I am able to engage in a few of my recreational activities because of pain in my neck.**
- **I can hardly do any recreational activities because of pain in my neck.**
- **I can't do any recreation activities at all**

SCORE:_____

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Name_____ Date_____

Modified Oswestry Low Back Pain Questionnaire: Please circle that most closely describes your problem

Section 1 - Pain Intensity

O The pain comes and goes and is very mild.
O The pain is mild and does not vary much.
O The pain comes and goes and is moderate.
O The pain is moderate and does not vary much.
O The pain comes and goes and is severe.
O The pain is severe and does not vary much.

Section 2 - Personal Care

O I do not have to change my way of washing or dressing to avoid pain.
O I do not normally change my way of washing or dressing even though it causes me pain.
O Washing and dressing increase the pain, but I manage not to change my way of doing it.
O Washing and dressing increases the pain and I find it necessary to change my way of doing it.
O Because of the pain I am unable to do some washing and dressing without help.
O Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

O I can lift heavy weights without extra low back pain.
O I can lift heavy weights but it causes extra pain.
O Pain prevents me lifting heavy weights off the floor.
O Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
O Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
O I can only lift light weights at the most.

Section 4 - Walking

O I have no pain walking.
O I have some pain on walking, but I can still walk my required to normal distances.
O Pain prevents me from walking long distances.
O Pain prevents me from walking intermediate distances.
O Pain prevents me from walking even short distances.
O Pain prevents me from walking at all.

Section 5 - Sitting

O Sitting does not cause me any pain.
O I can sit as long as I need provided I have my choice of sitting surfaces.
O Pain prevents me from sitting more than 1 hour.
O Pain prevents me from sitting more than 1/2 hour.
O Pain prevents me from sitting more than 10 minutes.
O Pain prevents me from sitting at all.

Section 6 - Standing

O I can stand as long as I want without pain.
O I have some pain while standing, but it does not increase with time.
O I can't stand for longer than 1 hour without increasing pain.
O I can't stand for longer than 1/2 hour without increasing pain.
O I cannot stand for longer than 10 minutes without increasing pain.
O I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

O I have no pain while in bed.
O I have pain in bed, but it does not prevent me from sleeping well.
O Because of pain I sleep only 3/4 of normal time.
O Because of pain I sleep only 1/2 of normal time.
O Because of pain I sleep only 1/4 of normal time.
O Pain prevents me from sleeping at all.

Section 8 - Social Life

O My social life is normal and gives me no pain.
O My social life in normal, but increases the degree of pain.
O Pain prevents me from participating in more energetic activities e.g. sports, dancing.
O Pain prevents me from going out very often.
O Pain has restricted my social life to my home.
O I hardly have any social life because of pain.

Section 9 - Driving

O I get no pain while traveling.
O I get some pain while traveling, but none of my usual forms of travel make it any worse.
O I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
O I get extra pain while traveling that requires me to seek alternative forms of travel.
O Pain restricts all forms of travel.
O Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

O My normal job/homemaking duties do not cause pain.
O My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
O I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
O Pain prevents me from doing anything but light duties.
O Pain prevents me from doing even light duties.
O Pain prevents me from performing any job or homemaking chores

SCORE:_____

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PATIENT INSURANCE INFORMATION

NAME:_____

PRIMARY
INSURANCE CARRIER: _____
MEMBER'S NAME: _____
SOCIAL SECURITY #: _____-_____-_____

SECONDARY
INSURANCE CARRIER: _____
MEMBER'S NAME: _____
SOCIAL SECURITY #: _____-_____-_____

- *I understand it is the policy of this office that should I choose to suspend or terminate care and treatment, any outstanding fees for professional services rendered to me will be immediately due and payable.*
- *I agree to pay all reasonable costs I incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. This provision also shall apply if I file a petition or any other claim for relief under any bankruptcy rule of law of the United States, or if such petition or other claim for relief is filed against me by another.*
- *I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.*
- *I authorize payment of medical benefits to the physician for services prescribed.*

OFFICE POLICY AND FEES

_____*FIRST VISIT: We ask that all patients pay at least 50% of their first day's charges when they check out. You can pay all or part of your charges by cash or check. For your convenience, we also accept Visa, MasterCard, and Discover. We do not accept American Express*

_____ *NUTRITIONAL SUPPLEMENTS AND SUPPORTS: We ask that any supplements, supports or orthotics be paid for when you pick them up Any special orders that are placed for you must be pre-paid before they are ordered.*

_____ *EMERGENCY CARE: Young Chiropractic & Acupuncture has a doctor on call 24 hours a day for emergency care. If you have an emergency, please call our office (359-0550) for instructions and an emergency number*.

Patient's Signature: _____ Date: _____

Responsible Party: _____ Date: _____

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Young Chiropractic & Acupuncture
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Notice of Privacy Practices

Effective September 1, 2013

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 ("Young Chiropractic & Acupuncture, Ltd."), 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, medical 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 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.

Thank You Acknowledgement - I acknowledge that Young Chiropractic & Acupuncture recognizes those who refer with some form of a thank you.

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
- 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.

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 so.

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 have 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.

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.

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, Security, or Complaint Officer as follows:

Name: **Dr. Kassie J. Young, D.C.**

Address: **2911 Crossing Court, Suite 101, Champaign, IL 61822** Telephone:**217-359-0550**