Mancini Chiropractic:
Wellness Center

Dr. Carol Mancini
Certified in Chiropractic Pediatrics
440 Main St. South
Southbury, CT 06488

Tel (203) 262-6347
Fax (203) 267-6155

Personal Information

Your Health Profile

NAME: PATIENT#: AGE: DATE:

ADDRESS:

CITY / STATE / ZIP:

HOME PHONE #: WORK PHONE#: CELL#:

E-MAIL ADDRESS: MALE FEMALE

BIRTH DATE: BEST TIME & NO. TO CONTACT:

OCCUPATION EMPLOYER'S NAME AND ADDRESS:

SINGLE: MARRIED: DIVORCED: WIDOWED:

NO OF CHILDREN: NAMES, AGES AND GENDER:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Your Health Profile

Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History." (next page)

Others, please briefly describe your chief concern, including the effect it has had on your life.

Health Concerns: list health concerns according to their severity.	Rate of Severity 1= mild 10=worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ache

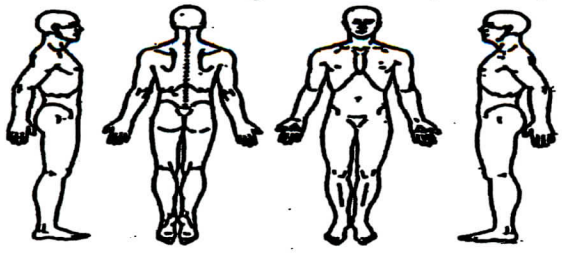
Does the pain travel/radiate anywhere: ☐ no ☐ yes - please describe

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?

◻ Excellent ◻ Very Good ◻ Good ◻ Fair ◻ Poor

17. What type of exercise do you do?

◻ Stenuous ◻ Moderate ◻ Light ◻ None

Race (Circle only 1) White American Indian/Alaska Native

Asia Black/African American

Native Hawaiian/Other Pacific Islander Declined to State

Ethnicity (Circle only 1) Not Hispanic or Latino Hispanic or Latino

Declined to State

Preferred Language: _____

FAMILY HISTORY	**Diabetes**	**Cancer**	**Back Pain**	**Other**
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

Have you ever had X-rays taken? ____**yes** ____**no When?**_____ **By Whom?**_____

For what ailments were these X-rays taken?_____

List all prescription medications you are currently taking:

_____

_____

List all over the counter medications you are currently taking:

_____

Have you ever been hospitalized? ___**Yes** ___**No If yes why**_____

List all surgical procedures you have had:

_____

What activities do you do at work?

Sit	__**Most of the day**	__**Half of the day**	__**A little of the day**
Stand	__**Most of the day**	__**Half of the day**	__**A little of the day**
Computer work	__**Most of the day**	__**Half of the day**	__**A little of the day**
On the Phone	__**Most of the day**	__**Half of the day**	__**A little of the day**

What activities do you do outside of work?_____

Have you had any significant past trauma? ___**Yes** ___**No**

Anything else pertinent to your visit today?_____

Clinic 1
Review of Systems

Patient Name: **Today's Date:**

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Is this condition interfering with your: () Sports/Exercise/Walking
() Positive mental Attitude () Hobbies () Other_____

What have you done for this condition that made you feel better?_____

What have you done that was of no help?_____

Have you had to or felt the need to make any "positive" changes in your life due to your condition? (ie. Eat better, less alcohol or drugs , meditate, less physical sports/activities?_____

Other Doctors seen for this condition () Chiropractor () Medical Dr. () Other

Name /Address:_____
Date:_____What was diagnosis?_____
What was done?_____

Name/Address:_____
Date:_____What was done?_____

ADULT(18 to present)	Yes	No
Do/did you smoke?	()	()
Do/did you drink alcohol ?	()How much?	()
Have you been in any accidents?	()	()
Do you play any adult sports?	()	()

If yes, what type of sports?_____

On scale of 1-10 describe your psychological/emotional stress: level 1=none,10=extreme
Occupational_____ Personal_____
On scale of 1-10 (1=very poor, 10 excellent) describe your:

Eating habits___ Exercise Habits___ Sleep____ General Health_____ Mind Set_____

I consent to a professional and complete chiropractic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____Date:_____
Thank you for filling out this form. It is your first step in CREATING WELLNESS.

MANCINI CHIROPRACTIC
440 MAIN STREET SOUTH
SOUTHBURY CT 06488
PH 203-262-6347
FAX 203-267-6156

CAROL M. MANCINI, D.C.
"Family care with a personal touch"

ACKNOWLEDGEMENT OF PRIVACY NOTICE BY MANCINI CHIROPRACTIC, LLC

By signing this form, you acknowledge you have read and understand the Notice of Privacy Practices from Mancini Chiropractic, LLC. The notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a revised copy by visiting our website at www.Mancinichiro.com.

____I have read and understand the Notice of Privacy Practices but I choose not to receive a written copy.

____I acknowledge receipt of a written copy of the Notice of Privacy Practices from Mancini Chiropractic, LLC.

_____ _____
Patient /Guardian **Date**

_____ _____
Compliance Officer **Date**

Mancini Chiropractic
A Creating Wellness Center
Tel (203)-262-6347
Fax (203) 267-6155

Dr. Carol Mancini
Certified in Chiropractic Pediatrics
440 Main Street South
Southbury, CT 06488

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the chiropractic physician and /or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services maybe performed by Carol Mancini, D.C. or other licensed Physicians of Chiropractic who my treat me now or in the future at this office. I have had the opportunity to discuss with Dr. Carol Mancini and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and others procedures. I understand that no guarantee can be given as to the results or outcome of my care.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment: including, but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known. The most common and likely side effect of treatment is muscle stiffness and soreness lasting one to several days.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stoke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before this stroke.

I have had the opportunity to read this form and my questions are answered to by satisfaction. I intend this consent form to cover the entire course for treatment of my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

_____ _____

Print Patient's Name Date

_____ _____

Signature of Patient, Guardian, Translator or Interpreter Date

Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the was:

___ Of legal Age ___ Consent given through Guardian ___ Appears unimpaired and competent

___ Fluent in English or assisted by a translator or interpreter ___ Signed in form voluntarily

_____ D.C. _____

Signature of Chiropractor Date

MANCINI CHIROPRACTIC

Dr. Carol Mancini

FINANCIAL AGREEMENT

We have attempted to provide you with the necessary information to determine the type of care you require and also financial information you may need to determine how your wish to handle your financial obligation to Mancini Chiropractic. We wish to make it very clear that your health is your sole responsibility, or your guardian. These polices apply only to the services actually performed and in no way obligate the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinued care.

HEALTH INSURANCE - You can choose either of the payment plans using your health insurance to finance your care at Mancini Chiropractic:

Submit your bills to your insurance company, Payment is expected at each visit. We will be happy to provide the appropriate information for your claim submission

Elect Mancini Chiropractic to submit your insurance claims. Although you are totally responsible for all charges incurred in this office. Mancini Chiropractic will submit these forms to your insurance company if you assign benefits to this office. You will pay for your yearly deductible and co payment at the time of each visit. If your insurance company fails to pay its share, you are responsible for paying your balance in full.

If you choose to assign benefits and your insurance company sends payment directly to your, that payment must be immediately endorsed and sent to Mancini Chiropractic. Remember, your contract with your insurance company is between you and them. Therefore, Mancini Chiropractic cannot enter into any disputes that may arise. However, we will be more than happy to complete any reports or send out records as requested.

Even if we are a network provider under your managed heath care plan, it is primarily your responsibility to know how your coverage works. This means that it is your responsibility to know any requirements for coverage of your care including but not limited to any need prior physician referral, treatment plans, plan limitations, and any other plan requirements.

Finally, please understand that we do not base your treatment program on your insurance coverage and neither should you. There is a limit to what your insurance company will pay. Many times, insurance coverage stops in the middle of a treatment program. If you discontinue your treatment, you may be walking out of our office with the same problem you walked in with. Therefore, we have committed to work around any financial problems as long as you have the commitment to achieve maximum health potential.

Cash - Payment is due at the time of service. Special arrangements for payment will be made on an individual basis

Workmans Compensation - My employer has agreed to pay for the services rendered by this office. I understand I am responsible for any portion of this bill that my employer or his/her insurance company refuses to pay

Medicare -We are a non-participating provider. Payments are due at time of service. You will be reimbursed directly by medicare for services they determine to be medically necessary.

Personal/Auto Accident - Although my insurance or lawsuit may eventually pay Mancini Chiropractic, I understand I may be asked to pay a weekly payment to be determined. If I used my insurance at any time , I understand I am responsible for all costs not covered. If I retain any attorney for litigation I must have my attorney issue a Letter Of Protection guaranteeing payment to this office. Any remaining balances will be my responsibility.

In the event I fail to pay as per agreed, I understand a monthly service charge will accrue on all outstanding balances. I also understand I am fully responsible for any attorney fees this office may incur in the cost of collections of my account.

PATIENT SIGNATURE

DATE

NOTICE OF PATIENT 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.

This Notice of Privacy Practices describes how *Mancini Chiropractic, LLC* may use and disclose your health information and how you can access this information. This Notice explains how we use and share your health information and describes your rights and our legal duties under federal and state privacy laws.

Who This Notice Applies To

This Notice of Privacy Practices applies to our chiropractic practice and all related services we provide, including those performed by our support staff and business associates who help deliver or manage your care. We follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Notice applies to you as a patient of our practice and to any services we provide in connection with your care.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.

Privacy Officer: *Michele Bridge*

Practice Name: *Mancini Chiropractic, LLC*
Address: *440 Main St South, Southbury, Ct. 06488*
Phone: (203) 262-6347

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

We may change the terms of this Notice from time to time. When we make a significant change, we will post the revised version in our office and, if applicable, on our website. You may obtain the current version at any time by contacting our Privacy Officer or asking at the front desk. You may contact our Privacy Officer in person at our office, by mail at the address above, or by phone.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information about you that may identify you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

Federal law (HIPAA) permits us to use and disclose your protected health information for treatment, payment, and health care operations without a separate written authorization, as described in this Notice.

Treatment

We may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes sharing information with other health care providers involved in your care.

Payment

We may use or disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, determining eligibility or coverage, utilization review, and related activities.

Health Care Operations

We may use or disclose your PHI to support the business operations of this practice, including quality assessment, employee training, internal audits, and administrative activities.

We may use sign-in sheets or call you by name in the waiting area as part of our normal operations, in a manner consistent with applicable privacy requirements.

BUSINESS ASSOCIATES

We may share your PHI with third-party "business associates" who perform services for us (such as billing, IT support, or transcription). These entities are required by contract to protect the privacy and security of your PHI.

To the extent applicable, we will require, through our agreements with that business associate, that they protect those records in accordance with applicable Part 2 confidentiality requirements.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. These include:

- Disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute a sale of PHI
- Other uses and disclosures not described in this Notice

Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2

Certain records related to Substance Use Disorder (SUD), if present in your record, receive additional confidentiality protections under federal law (42 C.F.R. Part 2).

Our primary services are chiropractic care. We are not a substance use disorder (SUD) treatment program as defined by federal law. However, we may receive or maintain information related to SUD treatment if you or another provider shares that information with us.

If our office maintains such information—such as information received from other providers, hospitals, or patient disclosures—those records generally will not be used or disclosed without your specific written authorization, except as otherwise permitted or required by federal law.

A standard authorization to release medical information may not be sufficient to permit disclosure of SUD-protected records. When required by law, we will obtain an authorization that specifically covers SUD information and complies with 42 C.F.R. Part 2. You may revoke your authorization for us to disclose SUD-protected records at any time by submitting a written request to our Privacy Officer. Revocation will not affect disclosures already made in reliance on your prior authorization.

Most patients seen in our chiropractic practice will not have records covered by these special rules. This section applies only if we receive or maintain information from an SUD treatment program.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may use or disclose your PHI without your authorization in the following situations:

Public Health & Safety - For public health activities, reporting communicable diseases, preventing serious threats to health or safety, and as required by law.

Health Oversight - To health oversight agencies for audits, investigations, inspections, and compliance activities.

Abuse, Neglect, or Domestic Violence - As required or permitted by law to appropriate authorities.

Workers' Compensation - As authorized to comply with workers' compensation laws.

Required by Law - When disclosure is required by federal, state, or local law.

Important Note About SUD Records: Some disclosures described in this section do not apply to records protected by 42 C.F.R. Part 2. Please see the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for information about how we handle SUD-protected records.

LEGAL PROCEEDINGS & LAW ENFORCEMENT

We may disclose PHI in response to a valid court order, subpoena, discovery request, or other lawful process as permitted by law.

Important: Records protected under federal Substance Use Disorder confidentiality regulations (42 C.F.R. Part 2), if applicable, may only be disclosed pursuant to a court order that specifically authorizes such disclosure or as otherwise permitted by federal law. A subpoena or legal request alone may not be sufficient for disclosure of SUD-protected information.

If we maintain records protected by 42 C.F.R. Part 2, those records are subject to stricter rules than other PHI. Please refer to the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for details.

YOUR RIGHTS

You have the right to:

- **Inspect and Copy** – You may inspect and obtain a copy of your PHI, subject to certain legal exceptions and reasonable, cost-based fees.
- **Request Restrictions** – You may request limits on certain uses or disclosures of your PHI; however, we are not required to agree to all requests.
- **Confidential Communications** – You may request that we communicate with you by alternative means or at alternative locations.
- **Amend** – You may request that we amend your PHI if you believe it is incorrect or incomplete.
- **Accounting of Disclosures** – You may request an accounting of certain disclosures of your PHI as defined by law.
- **Breach Notification** – If there is a breach of your unsecured PHI, we will notify you as required by applicable law.
- **Paper Copy** – You may request a paper copy of this Notice at any time.

To exercise any of these rights, please submit a written request to our Privacy Officer.

SPECIAL RIGHTS REGARDING SUD RECORDS

If our office maintains records protected under 42 C.F.R. Part 2, you have additional rights related to those records. Disclosure of such information generally requires your written authorization, and you may revoke that authorization at any time. Revocation will not apply to disclosures already made in reliance on your authorization.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services by visiting www.hhs.gov/hipaa or calling 1-800-368-1019.

To file a complaint with our office, please contact the Privacy Officer at the address or phone number listed above. You will not be penalized or retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective as of:

February 16, 2026
