Confidential Patient Health Record *Today's Date*: ____/_____/________

How did you hear about us? ☐Family _______________ ☐ Friend _________________ ☐ Co-Worker ________________
☐ Close to home/work ☐ Dr. _____________ ☐ Yellow pages ☐ Drove by ☐ Insurance Plan ☐ Internet/Website
☐ Health Fair ☐ Other: ___________________

Personal Information

Last: _____________________________ First: ______________________________ Middle: ______________________________
Birth Date: ____ /____/_______ Age: ______ Sex: ☐Male ☐Female Social Security #: ________-________-_________
Home Phone: (_______) ________-_________ Cell Phone: (_______) ________-_________
Email Address: ________________________________
Preferred contact method: ☐Home Phone ☐Cell Phone ☐Email
Address: ____Apt # ______
City: ____________________ State: ______ Zip: _________ Country: ____________________ County: ______________
Primary Language: ☐English ☐French ☐German ☐Spanish ☐other: ______________________________________
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Emergency Contact

Last: _____________________________ First: ______________________________ Middle: ______________________________
Address: ____Apt # ______
City: ____________________ State: ______ Zip: _________ Country: ____________________ County: ______________
Relationship: ☐Spouse ☐Relative ☐Friend ☐Other: ________________________
Email Address: ________________________________
Home Phone: (_______) ________-_________ Cell Phone: (_______) ________-_________

Consent to treat a minor:

Name of Minor: ____
Name of Responsible Party: ____
Relationship to Minor: □ Mother □ Father □ Other ____________________________________
Home Phone: ____________________________________ Cell Phone: _____________________________________
Work Phone: ____________________________________ Email: ____
Occupation: ____
Business/Employer Name: ____
Address: ____
City: ____ State: _________ Zip: ____________________

I, the parent or guardian of ____, a minor, the age of ________, do hereby consent, authorize and request SCUHS clinic doctors and interns to administer such treatment deemed advisable. I agree to hold these doctors and interns free and harmless from any claims and suites for damages or complications that may result from such treatments.

Patient/Guardian Signature: ____ Date: _________________
Witness Signature: ____ Date: _________________

Insurance Information:

Who Is Responsible for Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY
☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific): _______________

Insurance Company: ___________________ Health ID Card #: ______________________________
Policy Holder's Name: _______________________________ Group/Policy #: _______________________________________
Policy Holder's Date of Birth: _________________________ Relationship to Policy Holder: ___________________________
Policy Holder's Social Security #: ______-_____-_______ Policy Holder's Phone #: _______________________________

If you will be using Insurance Benefits to cover services, please complete and sign below:

I hereby instruct the insurance company listed above to pay by check made out to and mailed directly to the following address. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

ARIZONA CHIROPRACTIC & HOLISTIC HEALTH CENTER
20831 N. SCOTTSDALE RD, SCOTTSDALE, AZ 85255

For the professional or medical expense-benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that I will· be responsible for payment to any other facilities and/or health care providers that I may be referred to by Arizona Chiropractic and Holistic Health Center and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case. I hereby authorize the physician to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient [or Parent/Guardian] Signature: ____ Date: ____________

If you do not have Insurance that cover services, please read and sign below:

I hereby acknowledge that I have no insurance that covers services, and I understand that all services are payable when treatment is rendered. I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Arizona Chiropractic and Holistic Health Center and any emergency transporting that may be required thereto.

I further acknowledge that the fees I am paying are discounted from the usual and customary fees for services and the discounted fees I am paying are being applied to the usual fees. In the event that my insurance status changes and/or I elect to use a third-party payer, the standard fees may apply.

Patient [or Parent/Guardian] Signature: ____ Date: ____________

REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional:	☐ I DENY having or have had any of the symptoms or problems listed below.

☐ fever	☐ fatigue	☐ weakness	☐ unintended weight loss
☐ chills	☐ daytime drowsiness		☐ unintended weight gain

Eyes/Vision:	☐ I DENY having any of the symptoms or problems listed below.

☐ blindness	☐ change in vision	☐ field cuts	☐ photophobia
☐ blurred vision	☐ double vision	☐ glaucoma	☐ tearing
☐ cataracts	☐ eye pain	☐ itching	☐ wear glasses/contacts

Ears, Nose and Throat:	☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding	☐ ear drainage	☐ history of head injury	☐ nosebleeds
☐ sore throat	☐ ear pain	☐ fainting	☐ postnasal drip
☐ dentures	☐ tinnitus (ringing in ears)	☐ dizziness	☐ rhinorrhea (runny nose)
☐ difficulty swallowing	☐ hearing loss	☐ headaches	☐ loss of sense of smell
☐ hoarseness	☐ discharge	☐ TMJ problems	☐ sinus infections
☐ frequent sore throats	☐ altered taste	☐ snoring	☐ nasal congestion

Respiration:	☐ I DENY having any of the symptoms or problems listed below.

☐ asthma	☐ coughing up blood	☐ sputum production
☐ cough	☐ shortness of breath	☐ wheezing

Cardiovascular:	☐ I DENY having any of the symptoms or problems listed below.

☐chest pain	☐high blood pressure	☐shortness of breath with exertion or exercise
☐chest pressure	☐low blood pressure	☐angina (chest pain or discomfort)
☐chest discomfort	☐swelling of legs	☐paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)
☐palpitations	☐claudication (leg pain/ache)	☐orthopnea (difficulty breathing lying down)
☐heart problems	☐varicose veins	☐racing heart beat
☐ulcers	☐heart murmur	

Gastrointestinal:	☐ I DENY having any of the symptoms or problems listed below.

☐ nausea	☐ constipation	☐ abnormal stool caliber	☐ vomiting blood
☐ vomiting	☐ black - tarry stools	☐ jaundice	☐ abnormal stool color
☐ abdominal pain	☐ hemorrhoids	☐ indigestion	☐ abnormal stool consistency
☐ diarrhea	☐ rectal bleeding	☐ heartburn	☐ belching

Female:	☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding
☐ breast lumps/pain	☐ frequent urination	☐ pregnancy	☐ vaginal discharge
☐ burning urination	☐ hormone therapy	☐ urine retention	

Male: ☐ I DENY having any of the symptoms or problems listed below.

☐ burning urination ☐ erectile dysfunction	☐ frequent urination ☐ hesitancy/ dribbling	☐ prostate problems ☐ urine retention

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ cold intolerance ☐ heat intolerance ☐ excessive appetite ☐ excessive sweating	☐ excessive hunger ☐ excessive thirst ☐ abnormal frequency of urination ☐ night sweats	☐ goiter ☐ hair loss	☐ unusual hair growth ☐ voice changes ☐ diabetes

Skin: ☐ I DENY having any of the symptoms or problems listed below.

☐ changes in nail texture ☐ changes in skin color ☐ history of skin disorders	☐ hair loss ☐ Eczema ☐ Dermatitis	☐ itching ☐ rash	☐ skin lesions / ulcers ☐ varicosities

Nervous System: ☐ I DENY having any of the symptoms or problems listed below.

☐ dizziness ☐ facial weakness ☐ tremor ☐ clumsiness	☐ limb weakness ☐ loss of consciousness ☐ unsteadiness of gait/loss of balance ☐ change in bowel/bladder control ☐ numbness/tingling in hands/feet	☐ seizures ☐ sleep disturbance ☐ fainting ☐ headache ☐ migraines	☐ slurred speech ☐ History of stroke ☐ stress ☐ loss of memory

Psychologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ depression ☐ anxiety ☐ bi-polar disorder ☐ mood swings	☐ memory loss ☐ anhedonia (no desire) ☐ behavioral change	☐ convulsions ☐ confusion ☐ insomnia (unable to sleep)

Allergy: ☐ I DENY having any of the symptoms or problems listed below.

☐ anaphylaxis ☐ food intolerance	☐ itching ☐ acute nasal congestion	☐ chronic nasal congestion ☐ rash	☐ frequent sneezing ☐ hives

Hematologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ anemia ☐ bleeding	☐ blood clotting ☐ blood transfusion	☐ bruising easily ☐ fatigue	☐ lymph node swelling

PAST HEALTH HISTORY

Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition: ☐ I have not previously seen a doctor for this condition

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) ______________________
Type of Treatment: ____________________ Were you satisfied with the results of your treatment? ☐ Yes ☐ No
Explain: ____

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor

Doctor's Name: ________________________ Location: ______________________ Date of Last Visit: ___________
Were you satisfied with your care? ☐ Yes ☐ No, Why not? ____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.
☐ I DENY taking any medications

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, Supplements, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.
☐ I DENY taking any vitamins, herbs, supplements, etc.

Medication	Dosage	For What Condition?	How long have you been taking this?

Allergies: Mark all that apply below. ☐ I DENY having any allergies

☐ adhesive tape	☐ eggs	☐ newsprint	☐ shellfish
☐ animals	☐ feathers	☐ nuts	☐ smoke
☐ bee sting	☐ food coloring	☐ peanuts	☐ soap
☐ chocolate	☐ latex	☐ perfumes	☐ soy
☐ dairy	☐ mold	☐ pollen	☐ wheat
☐ other: _______________	☐ Sulfa drugs	☐ Penicillin	

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:
1. angioedema 3. GI disturbance 5. joint pain 7. shortness of breath
2. anaphylaxis 4. headache 6. rash 8. unspecified reaction

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.
☐ I DENY having any surgeries

☐ angioplasty	☐ D & C	☐ dental sugery	☐ tonsilectomy
☐ cosmetic	☐ joint reconstruction	☐ joint replacement	☐ carpal tunnel repair
☐ hysterectomy	☐ rotator cuff	☐ spinal fusion	☐ hemorrhoidectomy
☐ pacemaker insertion	☐ caesarian section	☐ cardic catheterization	☐ laminectomy
☐ appendectomy	☐ hernia repair	☐ gall bladder	☐ other:
☐ coronary artery bypass	☐ mastectomy	☐ knee repair	

Females ONLY: Ob/Gyn Mark all that apply below. ☐ I DENY having any of the symptoms or problems listed below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
☐ I am currently pregnant	☐ I am NOT currently pregnant

Menstrual History.

I… ☐ currently have menses	☐ currently DO NOT have menses.
My menses… ☐ are regular	☐ are NOT regular
_____ Age of first menses	_____ Age when metaphase began
Date of last menses: ______/______/________	

Injuries/Hospitalizations: Mark or List All Injuries. Write the DATE of the Injury immediately afterward.
☐ I DENY having any serious injuries or hospitalizations.

☐ back injury	☐ disability (ies)	☐ head injury (no loss of consciousness)	☐ fracture
☐ car accident	☐ industrial accident	☐ soft tissue injury (moderate)	☐ fall (severe)
☐ broken bones	☐ laceration (severe)	☐ head injury (loss of consciousness)	☐ joint injury
☐ soft tissue injury (severe)	☐ other:	☐ soft tissue injury (mild)	
☐ Blood transfusions			

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.
☐ I DENY having any of the symptoms or problems listed below.

☐ alzheimers	☐ shingles	☐ cystic kidney disease	☐ past history of similar symptoms
☐ depression	☐ asthma	☐ hypertension	☐ lupus erythema (systemic)
☐ influenzal pneumonia	☐ eczema	☐ psychiatric problems	☐ lupus erythema (discoid)
☐ diabetes (insulin dep)	☐ seizures	☐ liver disease	☐ unspecified pleural effusion
☐ suicide attempt(s)	☐ arthritis	☐ diabetes (non insulin)	☐ heart disease
☐ chicken pox	☐ scoliosis	☐ lung disease	☐ CRPS (RSDS)
☐ fibromyalgia	☐ anemia	☐ cancer	☐ hepatitis
☐ parkinson's disease	☐ vertigo	☐ emphysema	☐ pneumonia
☐ thyroid problems	☐ HIV	☐ STD's (unspecified)	☐ CVA (stroke)
☐ crohn's/colitis	☐ ADD	☐ cerebral palsy	☐ multiple sclerosis
☐ psoriasis		☐ eye problems	☐ other:

Social History: Mark all that apply below.

Alcohol: ☐ never used alcohol ☐ do not drink alcohol ☐ social consumption only ☐ Recovering alcoholic
☐ Drink the following regularly: ☐ beer ☐ liquor ☐ wine; quantity of ________ oz./glasses per ☐ day ☐ week ☐ month

Tobacco: ☐ never used tobacco ☐ Do not use tobacco ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker
☐ Quit smoking ☐ Smoke: # _____ per ☐ Day ☐ Week ☐ Month; ☐ Chew: #______cans per ☐ Day ☐ Week ☐ Year

Substance: ☐ never used illegal drugs ☐ has not used illegal drugs since __________ .
☐ never used IV drugs ☐ used illegal drugs for ______________ (how long?)

Family History: Mark all that apply below.	☐ I DENY having any family history of the problems below

Have any immediate or secondary family members ever been diagnosed with?			Family Member(s) Diagnosed:
Arthritis	☐ yes	☐ no	
Alcoholism	☐ yes	☐ no	
Blood Disorders	☐ yes	☐ no	
Bone Disorders	☐ yes	☐ no	
Cancers	☐ yes	☐ no	
Diabetes	☐ yes	☐ no	
Epilepsy	☐ yes	☐ no	
High Blood Pressure	☐ yes	☐ no	
Heart Disease	☐ yes	☐ no	
Auto-immune Disease	☐ yes	☐ no	
Stroke	☐ yes	☐ no	
Mental Health Disorder	☐ yes	☐ no	

X-ray Questionnaire:

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time.
☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time
☐ I request that x-ray films not be taken because:
☐ Date of last menstrual period:

Patient [or Parent/Guardian] Signature: ____ Date: ___________

INFORMED CONSENT FORM CHIROPRACTIC

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:
Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy bums due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

  Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt [(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery [(5)].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition [(6)]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine,* Oct 1 2007; 32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007; 30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008; 33(4 Suppl):S176-183,
4. Boyle E. Cote P, Grier AR, Cassidy JO. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008; 33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders, *Spine,* Feb 15 2008; 33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders, *Spine,* Feb 15 2008; 33(4 Suppl):S75-82.

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	NO	DOCTOR'S COMMENTS
GENERAL			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	☐	
BONE WEAKNESS			
Have you been diagnosed with osteoporosis?	☐	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	☐	
Have you ever been diagnosed with cancer?	☐	☐	
Do you have any metal implants?	☐	☐	
VASCULAR WEAKNESS			
Do you take aspirin or other pain medication on a regular basis?	☐	☐	
If yes, about how much do you take daily? _____			
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	☐	
Have you ever been diagnosed with any of the following disorders/diseases?			
• Rheumatoid arthritis	☐	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	☐	
• Giant cell arteritis (temporal arteritis)	☐	☐	
• Osteogenesis imperfecta	☐	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	☐	☐	
• Medial cystic necrosis (cystic mucoid degeneration)	☐	☐	
• Bechet's disease	☐	☐	
• Fibromuscular dysplasia	☐	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	☐	
SPINAL COMPROMISE OR INSTABILITY			
Have you had spinal surgery?	☐	☐	
If yes, when? _________			
Have you been diagnosed with spinal stenosis?	☐	☐	
Have you been diagnosed with spondylolisthesis?	☐	☐	
Have you had any of the following problems?			
• Sudden weakness in the arms or legs?	☐	☐	
• Numbness in the genital area?	☐	☐	
• Recent inability to urinate or lack of control when urinating?	☐	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient [or Parent/Guardian] Signature: ____ Date: ___________

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked .

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature . and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here.________ . Effective as of the date of first professional services.

if any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision . I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____________ Signature: _______________ Date: _______

Parent or Guardian: ___________ Signature: _______________ Date: _______

Witness Name: _____________ Signature: _______________ Date: ______

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of January 2, 2018, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations.

Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
>
> Payment: We may use and disclose your health information to obtain payment for services we provide to you.
>
> Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your

health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization, unless allowed by HIPAA.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you reasonable costs of labor associated with making copies including twenty-five (25) cents per page for copies or fifty (50) cents per page from microfilm, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Inspection of records will be allowed during normal business hours per appointment. A fee for locating, making the file available and being present during the review may be charged. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before January 2, 2018. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to

alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. These amendments will add to what is already in your file. Information that already exists will not be removed or altered. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:
Contact: Douglas Morris, D.C.
Telephone: 480-585-5577
Fax: 480-585-5566
E-mail: askdrdoug@hotmail.com
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*:*

I acknowledge that I have received the Notice of Privacy Practices of Arizona Chiropractic and Holistic Health Center, which describes the practice policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the practice. I have had the summary explained to me and understand the Practice will explain any questions I have regarding the complete privacy notice.

Patient [or Parent/Guardian] Signature: ____ Date: ___________
Printed Name ____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT*:*

The Practice has made a good-faith effort to obtain an acknowledgement of the patient's receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reason(s):

☐Patient unavailable ☐Patient unwilling ☐Patient physical unable ☐Other (describe):

On an effort to obtain the patient's acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner(s):

☐Personally ☐Phone follow-up ☐Mail ☐Other (describe):

Patient Name ____
Physician Signature ____ Date _________________
Printed Physician Name ____