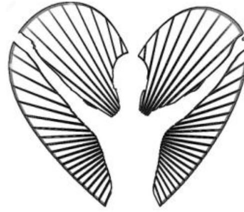
Whole Health Clinic



2819 Mahan Drive Ste. 102
Tallahassee, FL 32308
(850) 877-8980
(850) 671-1796 fax

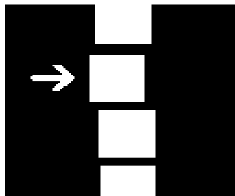
WELCOME

To Whole Health Clinic!

PLEASE TURN OFF YOUR CELL PHONE NOW.

You are to be congratulated on your insight into health and your desire to live a healthier, happier, longer life. Many people with less understanding will see the dentist twice a year for good looks and prevention of tooth and gum disease; they will service their new cars every few thousand miles...but they neglect their spinal health! Consider: you can get false teeth or a new car...but your spine, muscles, meridians, and nervous system are irreplaceable!

WHAT IS A SUBLUXATION? Every organ and structure, every muscle, bone, and blood vessel in your body is controlled and regulated by your nerves. And all of the nerves come from the spine. When a nerve is "short circuited", pinched, or compressed at the spine because the spine isn't working right, that is called a subluxation. Subluxations are often painful; sometimes they can cause numbness, tingling, headaches, spasms, twitches, and even problems with breathing, digestion, and other internal organs supplied by the affected nerve. Muscle imbalances and disturbances in *Chi* (energy) flow can cause these subluxations to become stubbornly entrenched.



THE BIG IDEA: Chiropractic as preventive health care: You, and every member of your family, need and deserve to have regular chiropractic checkups. Spinal injuries may begin in early childhood, even in the process of birth! Early childhood and adolescent falls and mishaps are responsible for a great many of the back, neck, and internal problems we experience as adults, sometimes without obvious reason.

Chiropractic adjustments have been shown to boost the activity of the body's immune cells. In short: ***Chiropractic is not just for your present need. It is lifetime preventive health care.***

What Happens Next?

ON YOUR FIRST VISIT, you will receive a no-charge consultation with the doctor. After reviewing your present problem and the overall state of your health, the doctor will let you know what additional services are needed and what the fees will be.

YOUR PRIVACY: We will never release your personal information to anyone without your authorization.

It is our prime objective to restore your health. After a thorough consultation, examination, and X-rays (if necessary), **IF WE BELIEVE YOU ARE NOT A CHIROPRACTIC CASE OR THAT WE CANNOT HELP YOU, WE WILL ADVISE YOU AND WILL NOT TREAT YOU, NOR WILL WE CONTINUE TREATMENT IF AT ANY TIME WE BELIEVE WE CAN NO LONGER HELP YOU.**

YOUR SECOND APPOINTMENT: is the report, to you, of the doctor's findings. Your spouse or other family members are encouraged to come along. The doctor will explain your examination and X-ray and her recommendations before any treatment is begun. He or she will also answer any questions that will help you fully to understand your problem and your health.

POST-TREATMENT INSTRUCTIONS: You may feel happy, light, relaxed, even euphoric after your adjustment. This is your body's normal response to being able to function normally again. You may feel some muscle soreness, like you've been lifting weights with your spine, the next day. This is the normal response of the muscles, which have been inactive, suddenly beginning to work again.

1. Avoid heavy lifting or more strenuous than usual exercise until the doctor advises you that it is okay. Your normal exercise routine is desirable, as long as it is not painful.
2. Avoid rubbing, poking, or probing in the area(s) your doctor adjusts.
3. Avoid sudden twists and turns of movement beyond your normal range of motion, especially of your neck.
4. Do your exercises and home therapy as instructed! We want you well <u>quickly</u>!

DAILY LIVING: Set aside time each day for complete mental and physical relaxation and/or prayer and meditation. When sitting, choose a chair which is firm enough to support your weight and which your feet rest comfortably on the floor. Avoid too-soft, overstuffed chairs. If you sit in a recliner, be sure to support your lower spine with throw pillows.

Cross your legs only at the ankles, not at the knees.

Be sure to get enough sleep. Although the average is seven and a half hours, some people only need four hours, while you may be one of those who need ten. Don't feel guilty! Sleep is healthful and necessary for your tissues to regenerate. You should sleep during the same time each day, in a silent, dark room with no disturbances or interruptions. Sleep on as firm a mattress as you can tolerate, with 2-3" of foam or pillowtop padding if needed. Waterbeds are <u>not</u> recommended. Do not read or watch TV in bed with your head propped at a sharp angle. Sit in a chair instead, or at least prop yourself with a bed wedge or multiple firm pillows into a semi-sitting posture with a pillow under your knees.

DIET: Recently, the old model of high-carbohydrates, low-fat diets has been replaced by a fashion or fad of high-protein, limited carbohydrate diets. Many people thrive on either type of diet, but some do well on high carbohydrates, and others do well on high protein. Most overweight people, diabetics and hypoglycemics, should stay on the high-protein side, while many active, "hyper" people, or people with weaker kidneys, become irritable and cannot function well on such a diet. Age, activity level, stress level, climate, and child-bearing can all change the optimal nutrient balance for an individual.

Whether you go with the high- or low-carbohydrate, high- or low-protein, some general rules should be followed:

1. Eat food as close to its natural state as possible:
   a. Whole wheat bread or pasta, instead of white.
   b. Fresh vegetables, lightly steamed or grilled, not deep-fried nor boiled until soft.
   c. Fresh fruits instead of cookies, pies or cakes.
2. Avoid artificial and partially-hydrogenated fats like margarine in favor of natural foods like butter, olive or safflower oil. Flax seed oil is even better, and virtually everyone can benefit from supplementation with 2-6 grams of fish oil for the Omega-3 fatty acids it contains.
3. Avoid foods with added sugar. Peanut butter, for example, should only contain peanuts and salt. Read labels and learn all the names for sugar, like corn-syrup, dextrose, maltose, sucrose, etc., etc.
4. Avoid Aspartame (Nutra-Sweet). There is evidence which links it to a variety of health problems in susceptible individuals. For more information on this subject, refer to several books on the subject available in the lending library of this clinic. For more specific dietary advice, ask the doctor. You may want to keep a diet diary that the doctor can review.

WHOLE HEALTH CLINIC FINANCIAL POLICY

At Whole Health Clinic, it is our mission to provide exceptional-quality health care. At the same time, we try to keep our fee schedule reasonable. For this reason, we must ask you to be honest and cooperative in paying for your treatment, so that we can concentrate on health care. The following policies help us do so:

1. All fees are due and payable when services are rendered unless prior arrangements have been made.

The only time this is *not* true is when services are paid for under Worker's Compensation, which does not allow the patient to pay at all, or under Blue Cross/ Blue Shield PPC, Cigna, or Medicaid, which allow us by contract only to collect a specific co-payment.

We accept checks, money orders, cash, Visa, MasterCard, American Express, and Discover for payment of services. HSAs and MSAs normally reimburse for medically necessary services you receive here.

What about Insurance Coverage?

We will postpone payment and accept insurance assignment on any policy which has been verified by our office staff. Please do not ask us to accept assignment on an unconfirmed policy or to take your word against your insurance company's that you have met your deductible.

We do not currently participate in any H.M.O. plans

2. Insurance assignment does not remove your responsibility for payment.

Insurance companies are allowed by law 30 days to pay their claims. We recognize your contract with your insurance company by deferring the balance for 30 days.

3. If the insurance company has not paid in 30 days, you are responsible for the balance.

Since we are not a party to your contract with the insurance company, we cannot be responsible for their payment or non-payment.

Service is a high priority for our billing staff, and we will provide all the documents and information the insurance company needs. In return, we ask that you promptly pay when you receive a bill for unpaid services. If you cannot meet this obligation in a timely fashion, we recommend borrowing the money from a commercial lending institution, such as a bank, credit union, finance company or credit card like Discover, MasterCard, or Visa to clear the balance. Interest will be applied at 12% APR to all patient balances more than 60 days past due.

(continued...)

4. Medicare.

We accept Medicare assignment for the only service Medicare covers at Whole Health: chiropractic adjustments necessary for treating a medical condition. Medicare may not even pay for this service, since their definition of "necessary" can be somewhat arbitrary. Medicare does not pay for massage, acupuncture, preparatory therapies, or adjustments for wellness care, so you will need to pay for these at the time of service.

5. Charges for missed appointments.

When you make an appointment, we are reserving a block of time to give you the best-quality holistic health care available. We ask for your courtesy in allowing another person to take that appointment if you cannot. *No charge is made for appointments cancelled with 24 hours' notice.*

We understand that emergencies happen, and all of us forget sometimes. However, if appointments are missed or canceled at the last minute without the presence of a bona fide emergency, you will be billed for a brief office visit beginning with the second missed appointment. Please note that insurance companies do not reimburse for missed appointments.

6. If you truly can't afford to pay.

At Whole Health Clinic, we recognize our obligation to provide care to those who lack the means to pay for life's necessities. If you or your child is in real physical distress and feel that you are in need of charitable or indigent care, please speak with Dr. Dwyer privately. Treatment for a token fee or sometimes even for free can be arranged.

Fee Schedule

Initial Consultation (by phone, by e-mail, or in person) ……NO CHARGE

THE PATIENT AND ANY OTHER PARTY RESPONSIBLE FOR PAYMENT HAS THE RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT WHICH IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT

Please note these fees do not apply to managed care contracts such as Blue Cross Blue Shield PPC, which have their own contractual fee schedules.

Examinations:

New Patients:

Infants (under age 1)	45.00
Brief	75.00
Moderate	180.00
Extended	210.00

Established Patients:

New Injury	35.00
Extended New Injury	87.00
Comprehensive/ Final	199.00

Services and Therapies:

Adjustments:

Spine 1-2 areas	45.00
Spine 3-4 areas	61.00
Spine 5 areas	79.00
Extremity	47.00
Heat/ Ice Packs	15.00
Electro Stimulation	24.00
Ultrasound	19.00
Kinetic Instruction	10.00-46.00
Hydrotherapy Bed	28.00
Acupuncture	65.00 + Exam

Lab Tests:

Lab tests are performed by Quest or LabCorp and are billed according to cost.

Minimum Off-Hours Fee: 75.00 (Plus services rendered)

House Call (City Limit): 200.00 (Plus services rendered)

Phone Consult (over 2 min):

2-10 minutes	10.00
10-20 minutes	20.00
20-30 minutes	40.00

Braces, Orthotics & Supplies:

Per Cost

Fitting/ Testing 35.00-65.00

Reports and Legal Testimony:

Reports 35.00-350.00

Court Appearances 350.00/hr(Portal to Portal)

Legal Testimony 350.00/hr

Massage Therapy:

(By Licensed Massage Therapist)

One Hour	197.44
Thirty Minutes	98.72

X-rays:

Cervical Spine:	
AP & Lateral	63.00
Full Series	98.00
Thoracic AP/Lat:	80.00
Lumbosacral AP/Lat:	80.00
Lumbar w/ Obliques:	88.00
Single Views:	35.00
Read Outside Films (per region read)	35.00

THE FOLLOWING FEES ARE DISCOUNTED IF PAID IN FULL AT THE TIME OF SERVICE ONLY:

Massage by Licensed Massage Therapist:	One Hour…65.00 **PAID IN FULL**
	30 minutes…45.00 **PAID IN FULL**
Unattended therapies:	15.00/ unlimited number **PAID IN FULL**
Spinal Adjustments, any number areas:	40.00 **PAID IN FULL**
Extremity Adjustments:	25.00 **PAID IN FULL**
Acupuncture/ Chinese Medicine:	Initial Visit…80.00
	Subsequent Visits…60.00

Whole Health Clinic
2819-102 Mahan Drive
Tallahassee, Fl. 32308

APPLICATION FOR TREATMENT

Today's Date:______/______/______
HOW DID YOU HEAR ABOUT OUR CLINIC?______________________________
NAME: Last:__________________ First: ____________________ Middle: ________________
SEX: M F **DATE OF BIRTH**:_____/_____/_____ **SOCIAL SEC**. #: ________-_______-________
E-MAIL: ____ ☐ Check here to receive e-newsletters.
PHONE: Home:__________________ Work: _____________________ Cell: ________________
ADDRESS: ____ APT #: _________
CITY: _________________________________ **STATE**: ___________ **ZIP CODE:** _____________
OCCUPATION: ______________________________ **EMPLOYER**: __________________________
SPOUSE OR EMERGENCY CONTACT: NAME: ____
Relationship:_____________ ADDRESS:___________________________________ APT #: __________
CITY: __________________________________ STATE: _________ ZIP CODE: _______________
PHONE: Home:_________________ Work: ______________________ Cell: ___________________

PLEASE READ OUR FINANCIAL POLICY (BLUE PAPER) CAREFULLY TO AVOID MISUNDERSTANDINGS!!!

INSURANCE INFORMATION
NAME OF INSURED: ____
PATIENT'S RELATIONSHIP TO INSURED: ____
INSURED'S ADDRESS: ____ APT #: ________
CITY: __________________________________ STATE: ____________ ZIP CODE: _______________
PRIMARY INSURANCE COMPANY NAME: ____
POLICY OR MEMBER ID#: ____
GROUP OR CLAIM #: ____
IS PATIENT HERE AS THE RESULT OF A WORK INJURY? YES NO
IF YES, DATE OF ACCIDENT: ______/______/______
IS THERE A WORKER'S COMPENSATION CLAIM FOR THIS INJURY? YES NO
IS PATIENT HERE AS THE RESULT OF AN ACCIDENT? YES NO
DATE OF ACCIDENT: ______/______/______ TYPE OF ACCIDENT (Please Circle)
AUTO HOME SPORTS WORK RECREATION OTHER
IS THERE AN ATTORNEY INVOLVED IN THIS CLAIM? YES NO
IF SO, NAME _________________________________ PHONE #: _________________________

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT: (ALL PATIENTS PLEASE SIGN)

I have read and understood the Whole Health Clinic Financial Policy provided to me with this form. I understand that I am responsible for payment for all services rendered by Whole Health Clinic, and that any insurance claims filed as a courtesy by the clinic are ultimately my responsibility. If payment is deferred pending insurance claims, I agree to pay the charge in full for any insurance claim which has not been paid within 60 days of the filing of the insurance claim. I understand that nay discounted fee allowed to me for payment at the time of service will be the charge submitted to my insurance carrier, if any, and that I am entitled to such a discount only if I make payment by cash, check, or credit card before the end of office hours on the date the service is rendered. I understand that discounts are not retroactive.

DATE ______/______/______ SIGNED ____

PARENT OR GUARDIAN'S CONSENT FOR TREATMENT OF A MINOR:

I, ______________________________, am parent or guardian of the minor described above, and I have authority to permit appropriate chiropractic examination and treatment procedures to be performed on him/her. This authorization shall remain in effect until I notify Whole Health Clinic in writing that I want it revoked.

DATE ______/______/______ SIGNED ____

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What is (are) your current problem(s) or reason(s) for being here? (Please list in order of importance to you)

1 ____ Since when?________________________
2 ____ Since when?________________________
3 ____ Since when?________________________
4 ____ Since when?________________________

Have you ever had the same or similar problem(s) before? YES NO

If yes, please explain ____

Which of your usual activities are limited by these problem(s)? ______________________

Have you seen any other health care provider concerning this (these) problem(s)?

YES NO If yes, please names, phone numbers &/or addresses: ________________________

Please list your family doctor and/or previous chiropractor:

M.D. ____ Date of last visit _____/_____/_____
D.C. ____________________________________ Date of last adjustment _____/_____/_____
Other ____

Please indicate your usage of these substances below. Use the reverse page if you need more space.

Alcoholic Drinks _____ # per week Caffeine _____ Cups/Drinks/Day Tobacco _____ # per day
Aspirin or other O.T.C. drugs: ____
Supplements or herbs: ____
Estrogen or Birth Control Pills: ____

Please list any current prescription for Drugs. Use reverse page if you need more space.

Drug ______________________ By Dr. __________________For Treatment of________________
Drug ______________________ By Dr. __________________For Treatment of________________
Drug ______________________ By Dr. __________________For Treatment of________________
Drug ______________________ By Dr. __________________For Treatment of________________
Drug ______________________ By Dr. __________________For Treatment of________________
Drug ______________________ By Dr. __________________For Treatment of________________

Please check any of these conditions which you have now or have had in the past:

- ☐ 1. Pacemaker
- ☐ 2. Asthma
- ☐ 3. Nerve Disorder
- ☐ 4. Migraines
- ☐ 5. Reconstructive surgery
- ☐ 6. Nerve or Muscle Disease
- ☐ 7. Osteoporosis
- ☐ 8. Brittle bones
- ☐ 9. Diabetes
- ☐ 10. Stroke
- ☐ 11. Heart Disease
- ☐ 12. Cancer
- ☐ 13. Kidney Disease
- ☐ 14. High Blood Pressure
- ☐ 15. Mental Illness
- ☐ 16. Depression
- ☐ 17. Scoliosis
- ☐ 18. Latex Allergy
- ☐ 19. Skin Allergy
- ☐ 20. Ulcers
- ☐ 21. Bone Surgery
- ☐ 22. Arthritis
- ☐ 23. Implants
- ☐ 24. Joint Surgery

Please check any of the following conditions which apply to blood relatives including parents, children, grandparents, siblings, uncles, or aunts:

- ☐ 1. Diabetes
- ☐ 2. Stroke
- ☐ 3. Mental Illness
- ☐ 4. Depression or Anxiety
- ☐ 5. Heart Disease
- ☐ 6. Cancer
- ☐ 7. Nerve Disease
- ☐ 8. Muscle Disease
- ☐ 9. Scoliosis

IF YOU HAVE NOT ALREADY DONE SO, PLEASE TURN OFF YOUR CELL PHONE NOW.

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Whole Health Clinic, Inc.
RELEASE OF PATIENT RECORDS AUTHORIZATION

I, ________________________ hereby authorize release of any office notes, lab, and radiology results, health or auto insurance benefits, including payment history information, containing protected health information, for the purpose of diagnosis and/or insurance billing to **Whole Health Clinic, Inc**. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

This authorization shall remain in effect until four years from the date below or until I notify Whole Health Clinic, Inc. in writing that I want it revoked.

____ ___________________

Patient's or Patient's Legal Representative' Signature   Patient's Date of Birth

____

Printed Name

____

Relation to Patient

____________________________________Date Signed

Specific description of information to be disclosed: _______________________________

____

____

____

TO WHOM MAY WE RELEASE YOUR HEALTH INFORMATION?

Whole Health Clinic
2819-102 Mahan Drive
Tallahassee, FL 32308

I, ____________________________ acknowledge and give permission to
Spouse____
Parent(s)____
Child(ren)____
Other: ____ to have access to the following:

Check items you give permission to this individual for
____ Pick up in the office medical records
____ Release information about test results
____ Release information about my account status
____Release information about appointments, missed visits, coordination of care with other physicians, lab results, accounts receivable, educational materials or any other items related to the continuation, coordination or item related to your healthcare treatment in our office.

This authorization shall remain in effect from the date signed below until:____

I understand that:

- I may inspect or copy the protected health information to be disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name________________________
Signature:______________________________ Relationship to Patient:______________________
Date:_______________

Witnessed by staff ____

Whole Health Clinic, Inc.
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

______________________________ __________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Whole Health Clinic
NOTICE OF PRIVACY PRACTICES
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.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

- (a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) Business Associate - To a business associate 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 or other payers.
- (c) Personal Representative -To a person who, under applicable law, has the authority to represent you in making decisions related to your health care
- (d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) 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.

- (e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
- (g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm
- (h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
- (i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
- (j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
- (k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- (l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- (m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
- (n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- (o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home or workplace and leaving a message on your answering machine or with the individual answering the phone.

SIGN-IN LOG AND PATIENT FOLDERS

The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices. Similarly, file folders for patients who have been seen on a given day are temporarily placed in a vertical file bin with only the patient’s name showing. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written authorization.

YOUR RIGHTS

1. You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time and to request a revocation, you must submit a written request to the Practice's COMPLIANCE OFFICER.
- (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law, however, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's COMPLIANCE OFFICER. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment
- (c) Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the Practice's COMPLIANCE OFFICER. The Practice will accommodate all reasonable requests.
- (d) Inspect and obtain a copy your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the Practice's COMPLIANCE OFFICER. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request
- (e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's COMPLIANCE OFFICER. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- (f) Receive an accounting of disclosures of your PHI as provided by law. The request should indicate in what form you want the list (such as a paper or electronic copy)
- (g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's COMPLIANCE OFFICER.
- (h) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202/619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850/414-3300, if you believe your privacy rights have been violated. To file

a complaint with the Practice, you must contact the Practice's COMPLIANCE OFFICER. All complaints must be in writing.

- (i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's COMPLIANCE OFFICER, Peri Dwyer, at 2819 Mahan Drive, Unit 102, Tallahassee, Florida 32308.

PRACTICE'S REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

  Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases and Section 456.057 relating to patient records ownership, control and disclosure.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact person appointed for this practice. The COMPLIANCE OFFICER is Peri Dwyer, DC.

You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the COMPLIANCE OFFICER. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of February 28, 2008

Whole Health Clinic, Inc.
2819 Mahan Drive Unit 102
Tallahassee, Florida 32308
850-877-8980 • www.wholehealthchiropractic.com

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient ____

Policy Holder ____

Claim/Group # ____

I hereby instruct and direct that ____
insurance company pay by check made out and mailed to:

Whole Health Clinic, Inc.
2819 Mahan Drive Suite 102
Tallahassee, FL 32308

If and only if my current policy explicitly prohibits direct payment to the doctor, then I hereby instruct and direct the insurer to make the check to me and mail it as follows:

c/o Whole Health Clinic, Inc.
2819 Mahan Drive Suite 102
Tallahassee, FL 32308

This applies to the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If claims are not paid within 30 days as provided by law, I authorize Whole Health Clinic, Inc. to file a complaint with the State of Florida Office of the Insurance Commissioner or other governing authority on my behalf.

I also authorize Whole Health Clinic, Inc. to a cause of action for any and all claims that have not been paid within 30 days as provided by law. This action includes a right to a requested copy of the policyholder's Policy of Declaration as well as a requested copy of the policyholder's payout log recorded by the insurer. I further authorize Whole Health Clinic, Inc. or its legal representative to file any and all Personal Injury Protection demand letters as well as subsequent Personal Injury Protection suits on my behalf.

A photocopy or facsimile of this document shall be considered as effective and valid as the original.

I also authorize the release of any information necessary to process this claim to any insurance company, adjuster, or attorney involved in this case.

Dated ____________________________, ______ at Whole Health Clinic, Inc.

________________________________   _________________________

Signature of Policyholder   Signature of Witness

____

Signature of Claimant, if other than Policyholder