Welcome to Body Integrations Chiropractic

Optimizing Your Health Through Nutritional & Structural Balance

Confidential Patient Health Record

Today's Date: _____/_____/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Dr. _____ ☐ Internet ☐ Google ☐ Instagram ☐ Yelp ☐ Alexa/Siri ☐ Facebook ☐ Building

Personal Information

Last: _____ **First:** _____ **Middle:** _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Birth Date: _____/_____/_____ **Age:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **Email Address:** _____

Emergency Contact

Last: _____ **First:** _____ **Middle:** _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Health Information

Height: _____ **Current weight:** _____

Are you under the care of a physician, If yes who? _____

Do you exercise? _____ **How often?** _____ **What type?** _____

How much weight would you like to lose? _____ **How many times a year do you diet?** _____

What new activities will you become involved in after losing the weight? _____

What areas of your body do you want to lose fat? _____

Cancellation Policy

24 hour notice is required to change an appointment without penalty.

It is very important that you are on time to your appointment. If you are late, this time will be deducted from your treatment time allowing us to stay on time for fellow patients. If you are going to be later than 15 minutes, you will need to reschedule your appointment.

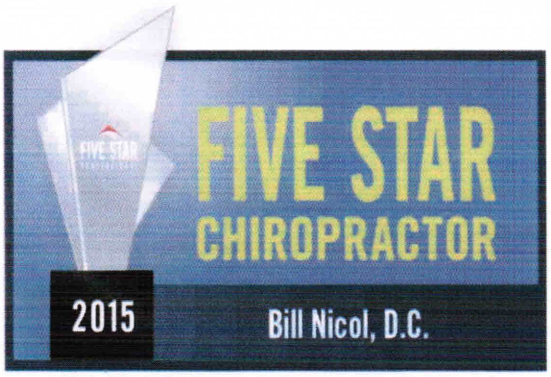
Dr Nicol and staff communicate to their patients via email and text messaging, example: appointment reminders, thank you notes, birthday cards and health articles. If you prefer not to receive this communication, please check the appropriate box(s) below.

☐ **Opt Out E-mail Messages** ☐ **Opt Out Text Messages**

I acknowledge that I understand the Cancellation Policy and have received the Clinic's Notice of Privacy Practices for protected health information

Patient Print Name: _____

X Patient's Signature:_____ Date: _____



Congratulations to Dr Nicol as one of the 2015 Five Star Chiropractors, for service to patients, who will be included in the April issue *of the Texas Monthly Magazine, in the Houston area.*

City Beat News congratulates those companies that demonstrate excellent customer service. Body Integration Chiropractic has won the Spectrum Award of Excellence and is most honored to have earned such high ratings for such a prestigious award.

Like us on Facebook – Go to "Body Integrations Chiropractic- Dr Bill Nicol" and receive current health topics.

BODY INTEGRATIONS CHIROPRACTIC

Treatment Consent Form

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Client understands the following:

1. Results vary greatly from person to Person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary *hyper* pigmentation/hypo pigmentation (changes in, skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by clients with any of the conditions Listed below.

Conditions that Prevent Treatment

Client agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AID
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding.

_____ I do not have a pacemaker.

SIGNATURE

By signing below, client agrees that Body Integrations Chiropractic may perform the Contour Light procedure for the purpose of body contouring. Client understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of client's knowledge.

Client Signature _____ Date _____

Client Printed Name _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Address:_____

Facility Name: Body Integrations Chiropractic

I have been given a copy of Body Integrations Chiropractic's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Body Integrations Chiropractic has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Body Integrations Chiropractic web site at www.awesthoustonchiropractor.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____

Signature of Facility Representative Date

William Nicol, DC

Print Name

File original in patient's Business Office Record

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

This Facility is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact Body Integrations Chiropractic at 713-781-3114.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Facility, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate heath professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility. This may include family members, or visiting nurses to provide care in your home.

- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at our Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients. We may disclose your age, birth date and general information about you in the Facility newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our Facility through contracts with business associates. Examples include medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Providers**. Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).

- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services and Reminders**. We may 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.

- **Fundraising Activities**. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you in raising money for the Facility. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Facility.

- **Facility Directory**. We may include information about you in the Facility directory while you are a patient. This information may include your name, location in the Facility, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the Facility and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation**. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
    - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
        - Prevention or control of disease, injury or disability
        - Reporting births and deaths;
        - Reporting child abuse or neglect;
        - Reporting reactions to medications or problems with products;
        - Notifying people of recalls of products;
        - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
        - Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- *Health Oversight Activities.* We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a patient has been the victim of abuse, neglect or domestic violence.

- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the Facility; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the Facility, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  You must submit your request in writing to Body Integrations Chiropractic. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

  You must submit your request in writing to Body Integrations Chiropractic__. In addition, you must provide a reason for your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the Facility; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

  You must submit your request in writing to Body Integrations Chiropractic. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before June 1, 2016. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  You must submit your request in writing to Body Integrations Chiropractic. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

  You must submit your request in writing to Body Integrations Chiropractic. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

- *You may obtain a copy of this Notice at our website, www.awesthoustonchiropractor.com*

  To obtain a paper copy of this Notice, contact Body Integrations Chiropractic.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify

the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the Facility, contact Body Integrations Chiropractic. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**