PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU ...THANK YOU.

Triangle Wellness and Sports Center, P.A.

Date: ______________________________ Referred by: ______________________________

Name: ______________________________ Phone: ______________________________

Address: ______________________________ City State Zip: ______________________________

Age: ______ Date of Birth: ____________ SS#: ______________________________

Sex: ____ Marital Status: S M W D Sep Spouse's Name: ______________________________

Employer: ______________________________ Spouse's Employer: ______________________________

Address: ______________________________ Address: ______________________________

City, State Zip: ______________________________ Email ______________________________

Email ______________________________ City, State Zip: ______________________________

Please give receptionist your card for photo copy

Insurance Information: Spouse Insurance Information

Company: ______________________________ Company: ______________________________

Policy #: ______________________________ Policy #: ______________________________

Group #: ______________________________ Group #: ______________________________

Phone #: ______________________________ Phone #: ______________________________

Payment Policy:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that it is a service of this office to assist in the preparation of any necessary reports and forms in making collection from the insurance company and I may be charged clerical fees. I authorize this office to release any information needed upon request from the insurance carrier. Any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

The payment policy is as follows: Payment in full is expected at the time of services rendered. The charge for professional time is up to $240.00 an hour. Charges will be broken down on the bill along with diagnosis and treatment codes. **You are responsible for filing your own insurance with the receipt provided to you. Reimbursement and allowance is determined by your insurance company.**

Office policy: This office retains the right to charge for missed appointments. Should I become inactive by discontinuing my care, I understand that my charges payable to this office will be due immediately. Outstanding balances not paid will be sent to a collection agency and 18% will be added to your account.

Patients Signature: ______________________________ Date: ______________

Your Appointments are as follows: ______________, ______________, ______________

PLEASE BRING A URINE SPECIMEN FROM FIRST THING IN THE MORNING BEFORE EATING!

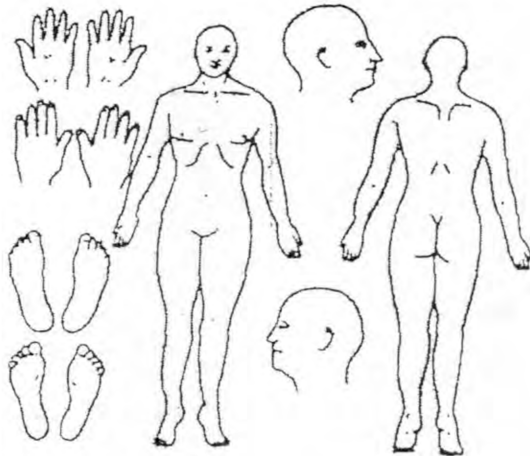
Triangle Wellness and Sports Center P.A.

Patient Name: ______________________ Date: ______________

Age: ______ Date of Birth: ______________ Referred by: ______________

!!! leave no blanks please. If the question does not apply indicate **N/A** !!!

Please outline on the diagram the areas of discomfort and describe: (mark these symbols on diagram)



Sharp **XXX** Dull **000** Stabbing **VVV**
Burning /// Numbness +++

Chief complaint: ______________

Indicate pain intensity on this scale with an x

0 ______________________ 10
no pain mild moderate severe

Secondary complaint: ______________

Indicate pain intensity on this scale with an x

0 ______________________ 10
no pain mild moderate severe

Describe injury / problem: ______________________

Does pain radiate into arms or legs ? ______________

Have you had this before? describe : ______________________

Please indicate which factors affect your trouble: no effect worse better

Standing ______________
Resting ______________
Walking ______________
First thing in morning ______________

End of day ______________
Movement ______________
Laying down ______________
Other ______________

Describe other methods used to relieve discomfort ie. other doctors, medicine, heat ice etc., and result:

____

Describe other symptoms that you are currently suffering ie. headaches, nausea, intestinal distress, irritability etc.

____

Triangle Wellness and Sports Center P.A.

Patient Name: ______________________ Date: ______________

Family History: indicate mother, father, sister, brother have had: (otherwise N/A)

Diabetes ______________ High blood pressure ______________

Cancer ______________ Heart disease ______________

Arthritis ______________ Other ______________

Past History:

Do you smoke? ________ years________ packs day ____________ around people who smoke? ________

Birth control pills? ______________ how long? ______________

List any Major diseases of which you have suffered or are currently suffering (give dates of diagnosis): ________

List all surgeries and hospitalizations (dates): ______________

Date of beginning of last menstrual period (females): ______________

Medications you are currently taking: ______________

Circle if you use:

alcohol white bread caffeine deli meats sugar equal sweet&low tap water

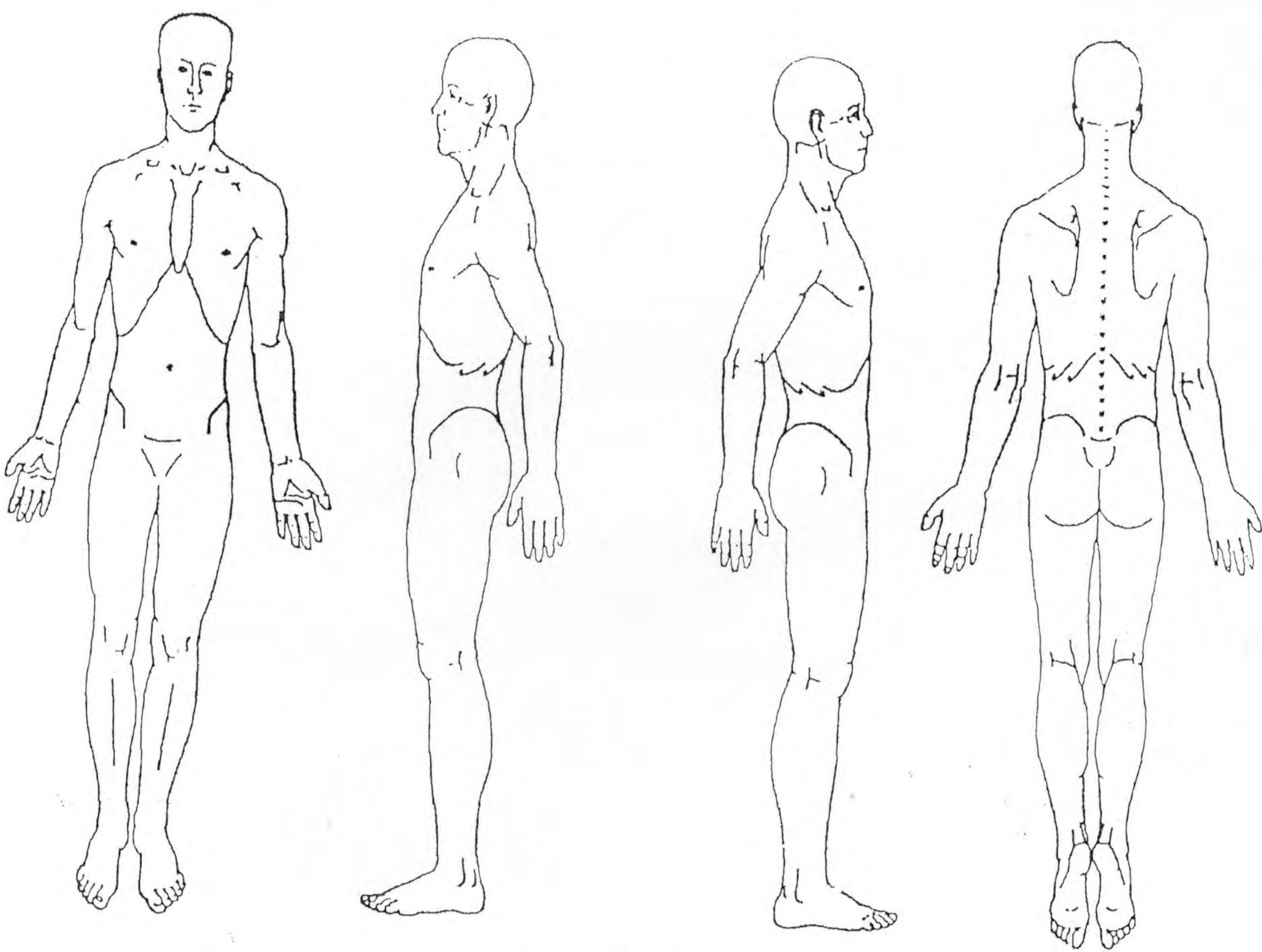
margarine fast food sodas aspirin / Tylenol antacids laxatives hormone replacement

Known Allergies: ______________

History of trauma:

Describe physical, emotional trauma and/or chemical exposures: ______________

Please indicate any additional information that you feel useful here:



History of Injury

Please mark with an "X" all the places on your body which have ever been injured (sprains, broken bones, severe bruises, falls and surgical scars, etc.)

FOOD INTAKE NAME: ______________________ DATE: __________

How many of each do you eat per week? Estimate as best as you can. Write number in each box.

	Srvgs/Wk
DAIRY	
Whole Milk	
Skim Milk	
Buttermilk	
Half & Half/Cream	
Yogurt	
Cheese	
Kind(s)	
Ice Cream	
Eggs	
MEAT/POULTRY/FISH	
Poultry	
Fish	
Other Seafood	
Beef	
Pork	
Bacon	
Liver	
Bologna/Cold Cuts	
Canned Meat	
NUTS & SEEDS	
Peanuts	
Peanut Butter	
Others: (Specify)	
GRAINS	
Cereals	
Sugar Coated Cereals	
Oatmeal	
Pancakes	
Waffles	
Crackers	
Rice	
Macaroni	
Spaghetti	
Slices of White Bread	
Slices of Wheat Bread	
Slices of Rye Bread	
Slices of Corn Bread	
Rolls	
Sweet Rolls & Muffins	
DESSERTS/SWEETS	
Pie	
Cake	
Cookies	
Doughnuts	
Jello	
Candy	
Chocolate	
Sweets most commonly eaten:	
VEGETABLES	
Asparagus	
Beans, Dried or String	
Brussel Sprouts	
Broccoli	
Cabbage	
Carrots	

Celery	
Cole Slaw	
Corn	
Green or Bell Peppers	
Green Peas	
Greens, Turnips etc.	
Lettuce	
Parsley/Cilantro	
Potatoes, White	
Potatoes, Sweet	
Spinach	
Squash, Summer	
Squash, Winter	
Onion	
Tomatoes	
Yams	
Others: (Specify)	
FRUITS	
Apples	
Applesauce	
Apricots	
Bananas	
Dates	
Figs	
Grapefruit	
Oranges	
Pears	
Pineapple	
Prunes	
Canned Fruits	
Dried or Frozen Fruit Type:	
Others: (Specify)	
BEVERAGES	**Glasses/wk**
Colas	
Uncolas	
Kool Aid, etc.	
Orange Juice	
Grapefruit Juice	
Grape Juice	
Tomato Juice	
Others: (Specify)	
Alcoholic Beverages: Type:	
Coffee	
Decaffeinated, Sanka	
Tea	
Herbal Tea	
Cream in coffee,tea,etc	Y N
White Sugar in coffee # Tsp/day	Y N
Artificial Sweeteners	Y N
Honey	Y N
Water	

Tap Water	Y N
FATS	
Pats of Butter	
Pats of Margarine	
What Vegetable oils, fats or other compounds do you use in cooking?	
What salad oil(s) do you use?	
RECENT MEALS & HABITS	
What did you eat yesterday for breakfast	
What did you eat yesterday for lunch?	
What did you eat yesterday for dinner?	
What did you eat yesterday for snacks?	
What beverages did you have yesterday?	
Do you use salt (x) Sparingly Moderately Freely	
Do you use vinegar (x) Sparingly Moderately Freely	
Is this your average diet for the past 3 or 4 years?	Y N
What foods, if any, disagree with you?	
Do you have/Are you:	**Yes/No**
Indigestion	
Fond of Bread	
Fond of Cereals/Grains	
Fond of Fried Foods	
Fond of Salty Foods	
Fond of Sweets	
Fond of Meats	
Fond of Fruits	
Fond of Vegetables	
Fond of (Specify)	

MSQ - Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Frequently have it, effect is not severe
3 = Occasionally have it, effect is severe
4 = Frequently have it, effect is severe

Category	Symptoms	Total
Digestive Tract	_____ Nausea or vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching or passing gas _____ Heartburn	_____
Ears	_____ Itchy Eyes _____ Ear aches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss	_____
Emotions	_____ Mood Swings _____ Anxiety, fear or nervousness _____ Anger, irritability or aggressiveness _____ Depression	_____
Energy & Activity	_____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness	_____
Eyes	_____ Watery or itchy eyes _____ Swollen, reddened or sticky eyelids _____ Bags or dark circles under eyes _____ Blurred or tunnel vision [does not include near or far sightedness]	_____
Head	_____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	_____
Heart	_____ Irregular or skipped heartbeat _____ Rapid or pounding heartbeat _____ Chest Pain	_____
Joints & Muscles	_____ Pain or aches in joints _____ Arthritis _____ Stiffness or limitation of movement _____ Pain or aches in muscles _____ Feeling of weakness or tiredness	_____
Lungs	_____ Chest Congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty Breathing	_____
Mind	_____ Poor memory _____ Confusion, poor comprehension _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities	_____
Mouth / Throat	_____ Chronic coughing _____ Gagging frequently; need to clear throat _____ Sore throat, hoarseness, loss of voice _____ Swollen or discolored tongue, gums, lips _____ Canker sores	_____
Nose	_____ Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____ Excessive mucus formation	_____
Skin	_____ Acne _____ Hives, rashes, or dry skin _____ Hair loss _____ Flushing or hot flashes _____ Excessive sweating	_____
Weight	_____ Binge eating/ drinking _____ Craving certain foods _____ Excessive weight _____ Compulsive eating _____ Water retention _____ Underweight	_____
Other	_____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge	_____
Grand Total		_____

HEALTH APPRAISAL - BRIEF

NAME______________________________ DATE__________

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer the the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

Symptom				
1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points__________

Section B

Symptom				
1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Specific foods/beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points__________

Section C

Symptom				
1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections; difficulty breathing	0	1	2	3
8. For relief from carbonated beverages, cream/milk/food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points__________

Section D

Symptom				
1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points__________

PART II

Section A

Symptom				
1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3
12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points__________

John R. Schmitt, DC

(919) 847-3555

Notice of Privacy Practices

Effective Date: September 23rd, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact: Dr. John Schmitt at (919) 847-3555182 Wind Chime Court, Suite 203

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 include, for example, 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 include, for example, 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer

disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 ., Raleigh, NC 27615. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected

Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you may ask the receptionist in our office, or you may submit a written request to: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact: Dr. John Schmitt, 182 Wind Chime Court, Suite 203 Rd, Raleigh, NC 27615. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave., S.W.
Room 509F HHH Building
Washington, DC 20201

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit the US Department of Health & Human Services web site: http://www.hhs.gov/ocr/privacy/index.html or call: Toll Free: 1-877-696-6775.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide JohnH. Schmitt, DC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. I also acknowledge that I can obtain a paper copy of this notice at any time upon request.

_______________________________ _______________

Patient Name (print) Date

_______________________________ _______________

Patient Signature or Authorized Provider Representative Date