360 INTEGRATED MEDICAL CENTER — A Team Approach to Total Health™
BH Back to Health Wellness Center

2504 Monroe Street, LaPorte, IN 46350
PH: (219) 326-5100 FX: (219) 326-0180

Confidential Patient Intake Form

WELCOME TO OUR OFFICE! Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent medical records and will help us get a better understanding of your overall health. Please ask if you have any questions or concerns while completing this form. THANK YOU!

PERSONAL INFORMATION

Patient Legal Name: ______________________________ **Date:** ______/______/_______
Date of Birth: ______/______/______ **Age:** ______ **Sex:** ❑ Male ❑ Female **Marital Status:** S / M / D / W
SSN: ______/______/________ **Home Phone:** (_____) ______-________ **Cell Phone:** (_____) ______-________
Address: ______________________ **City:** ______________ **State:** _____ **Zip:** __________
Email: ______________________ **Occupation:** ______________________
Employer Name/City: ______________________ **Work Phone:** (_____) ______-________
Spouse or Guardian's Name: ______________________ **How Many Children (Ages):** ______________
Spouse's Employer: ______________________ **Spouse's SSN:** ______/______/________
Emergency Contact: ______________________ **Phone:** (_____) ______-________
Whom May We Thank for Referring You to Us? ______________________
How Else Did You Hear About Us? ______________________

If Patient is School Age (15+), I Authorize Treatment in My Absence esp. In Case of Medical Emergency (GUARDIAN SIGN BELOW):
Legal Guardian Signature: ______________________ Patient Relation: ______________ Date: __________

RESPONSIBLE PARTY – Do You Currently Have Medical Insurance? ❑ No ❑ Yes (complete the following:)

Who is Responsible for Your Account: ❑Myself Only ❑Myself AND: Spouse / Work Comp / Auto Insur. / Health Insur.
Personal Health Insurance Carrier: ______________________ **Health ID Card #:** ______________
Policy Holder's Name: ______________________ **Group #:** ______________
Policy Holder's Social Security #: ______/______/________ **Primary Care Physician:** ______________

ASSIGNMENT OF HEALTH BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **360 Integrated Medical Center PC and/or Back to Health Wellness Center PC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of ______________, 20_____. **Patient Signature:** X______________________

Print Patient Name: ______________________ Guardian Signature (if applicable): ______________________

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Patient Name: ____ Date: _____/_____/______

CHIEF COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

What is Your MAIN SYMPTOM? ____
Location (Where is your main pain/problem?): ____
Quality (Describe this pain/problem): ____
Duration (When did this pain/problem start?): ____
Cause (What started this pain/problem?): ____
Severity (How severe is this pain/problem?): ____
Frequency (How often is this pain/problem?): ____
Timing (Worse in morning, night, constant?): ____
Change (Getting better, worse, same over time?): ____
Relieving Factors (What activities make it better?): ____
Aggravating Factors (What activities make it worse?): ____
Radiation (Other body areas affected by this pain/problem?): ____

OTHER HEALTH COMPLAINTS

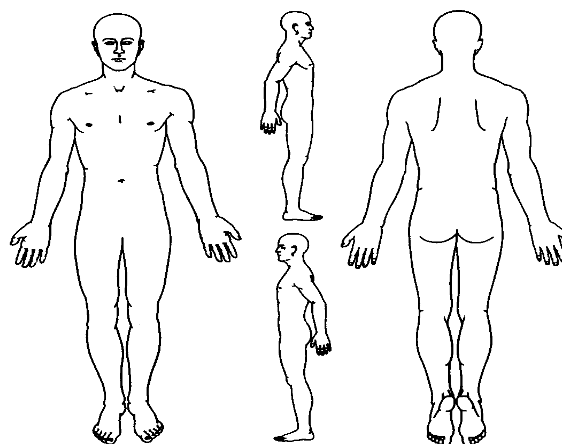
Please list health complaints you are having currently and mark location(s) on the diagram using the "Key". Then indicate below the severity of the symptom(s) from 1 to 10 with 10 being worst.

No Pain ▼ Worst Pain ▼

Primary Complaint:
1)______________________ 1 2 3 4 5 6 7 8 9 10

Additional Complaints
2)______________________ 1 2 3 4 5 6 7 8 9 10
3)______________________ 1 2 3 4 5 6 7 8 9 10
4)______________________ 1 2 3 4 5 6 7 8 9 10
5)______________________ 1 2 3 4 5 6 7 8 9 10

Diagram Key: A=Ache, B=Burning, N=Numbness, P=Pin & Needles, S=Sharp



ACTIVITIES OF DAILY LIVING

Work Status: ❑Employed ❑Unemployed ❑Retired ❑Disabled ❑Student ❑Stay-at-home ❑Other: __________
Usual Daily Activities: ❑Bend ❑Reach ❑Climb ❑Sit ❑Kneel ❑Stand ❑Pull ❑Twist ❑Push ❑Walk ❑Lift
Repetitive Activities: ❑Assembly/Fine Manipulation ❑Hand Tool Use ❑Computer Use/Typing ❑Operate Machinery ❑Grasping ❑Phone Use ❑Other: ______________________________
How Has Primary Condition Affected Job Performance? ❑No Effect ❑Limited Ability ❑Can't Perform Normal Duties
How Has Primary Condition Affected Daily Activities?

Bending:	❑No Effect	❑Mild	❑Moderate	❑Severe	Lifting:	❑No Effect ❑Mild	❑Moderate	❑Severe
Changing Positions:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sleeping:	❑No Effect ❑Mild	❑Moderate	❑Severe
Climbing Stairs:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sitting:	❑No Effect ❑Mild	❑Moderate	❑Severe
Driving:	❑No Effect	❑Mild	❑Moderate	❑Severe	Standing:	❑No Effect ❑Mild	❑Moderate	❑Severe
Computer Use:	❑No Effect	❑Mild	❑Moderate	❑Severe	Walking:	❑No Effect ❑Mild	❑Moderate	❑Severe
Household Chores:	❑No Effect	❑Mild	❑Moderate	❑Severe	Yard Work:	❑No Effect ❑Mild	❑Moderate	❑Severe

How Has Primary Condition Affected Recreational Activities? ____
____

Provider APN/MD Signature: ______________________________________ Date: _____/_____/_____

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Patient Name: ______________________________ Date: ______/______/______

PAST MEDICAL HISTORY

Height: ______ft. ______in. **Current Weight:** _________lbs. **Recently Lost or Gained More Than 10 lbs?** ❑Yes ❑No

Last Physical Exam Date and Results? ______________________________

Have You Seen Other Physicians/Providers for THIS Main Primary Condition? ❑Yes ❑No

If Yes, List All Doctors or Therapist Consulted for THIS Condition (include approximate dates and diagnosis).

Provider Name: ____________________ Date of Visit: __________ Diagnosis: ____________________

Provider Name: ____________________ Date of Visit: __________ Diagnosis: ____________________

Describe Any Treatment You've Had for THIS Condition (include medications, testing, etc.): ______________________________

____

Have You Ever Received Chiropractic Care? ❑No ❑Yes: When? ____________________ Satisfied with Care? ❑Yes ❑No

MEDICATIONS & ALLERGIES

List Any Prescription & Non-Prescription Medications, Vitamins You Are Currently Taking: ❑ Not Taking Any Meds

Medication	Dosage	For What Condition?	How Long Been Taking This?

List Any Allergies, Including Sulfa, Seasonal, Food and Medicinal Allergies: ❑ No Known Allergies

Allergen	Reaction to Allergen

PAST HOSPITALIZATIONS & SURGERIES

Please Indicate If You Have Had the Following Surgeries:

- ❑ Carpal Tunnel Surgery Date: ______________
- ❑ Laminectomy Date: ______________
- ❑ Joint Reconstruction Date: ______________
- ❑ Joint Replacement Date: ______________
- ❑ Rotator Cuff Repair Date: ______________
- ❑ Knee Repair Date: ______________
- ❑ Spinal Fusion Date: ______________
- ❑ Spinal Disc Surgery Date: ______________

List Any Other Past Hospitalizations and Surgeries: ______________________________

____

____

PAST INJURIES

Please Indicate If You Have Had the Following Injuries:

- ❑ Back Injury Date: ______________
- ❑ Joint Injury Date: ______________
- ❑ Broken Bones Date: ______________
- ❑ Head Injury Date: ______________
- ❑ Severe Fall Date: ______________
- ❑ Auto Accident Date: ______________
- ❑ Sprain/Strain Date: ______________
- ❑ Severe Laceration Date: ______________

List Any Other Past Major Injuries: ______________________________

____

____

Provider APN/MD Signature: ______________________________ Date: ______/______/______

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Patient Name: ____ Date: ______/______/_______

PAST ILLNESSES/DISEASES

Please Indicate If You Have Ever Had the Following Illnesses:

❑ Measles	❑ Pneumonia	❑ Asthma	❑ Hepatitis	❑ Anemia
❑ Mumps	❑ Rheumatic Fever	❑ Eczema Hives	❑ Ulcer	❑ Bladder Infection
❑ Chicken Pox	❑ Arthritis	❑ AIDS & HIV	❑ Kidney Disease	❑ Epilepsy
❑ Whooping Cough	❑ Venereal Disease	❑ Infectious Mon	❑ Thyroid Disease	❑ Migraine Headaches
❑ Scarlet Fever	❑ Polio	❑ Bronchitis	❑ Blood Clots	❑ Blood Pressure Issue
❑ Diphtheria	❑ Tuberculosis	❑ Mitral Valve Prolapse	❑ Cancer	❑ Glaucoma
❑ Small Pox	❑ Diabetes	❑ Stroke	❑ Bleeding Tendency	❑ Hemorrhoids

List Any Other Past Serious Illnesses or Disease: ____

____

REVIEW OF SYSTEMS

Please Indicate Any of the Following You Have Experienced in the Last 1-2 months.
Please Circle the Number According to Frequency: **1=Never, 2=Rarely, 3=Occasionally, 4=Frequently, 5=Constantly**

General & EENT		Musculoskeletal		Neurological	
Weakness	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Fatigue	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Chills	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Night Sweats	1 2 3 4 5	Joint Stiffness	1 2 3 4 5	Tingling	1 2 3 4 5
Fainting	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Seizures	1 2 3 4 5
Asthma	1 2 3 4 5	Neck Pain	1 2 3 4 5	Vertigo	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Mid Back Pain	1 2 3 4 5	Trembling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	Weak Grip	1 2 3 4 5
Earache/Infection	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Incoordination	1 2 3 4 5
Shortness Breath	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Paralysis	1 2 3 4 5
Wheezing	1 2 3 4 5	Hip Pain	1 2 3 4 5	Memory Loss	1 2 3 4 5
Ear Ringing	1 2 3 4 5	Knee Pain	1 2 3 4 5	Speech Difficulty	1 2 3 4 5
Skin Changes	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Facial Loss	1 2 3 4 5

PATIENT SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Daily Mental Work Load: ❑ None ❑ Light (1-2 hours) ❑ Moderate (3-4 hours) ❑ Heavy (5+ hours)
Daily Physical Work Load: ❑ None ❑ Light (1-2 hours) ❑ Moderate (3-4 hours) ❑ Heavy (5+ hours)
Weekly Exercise Habits: ❑ No Exercise ❑ Light (1 day/wk) ❑ Moderate (2-3 days/wk) ❑ Heavy (4+ days/wk)
Use of Alcohol (Beer, Wine, Liquor): ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of Tobacco/Smoking: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of Drugs: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily : Type/Frequency: ______________________

FAMILY MEDICAL HISTORY

List Any Diseases or Illnesses Which Run in Your Family

	Age if Living	Age at Death	Disease/Illness	Cause of Death	State of Health
Father					
Mother					
Brother(s)					
Sister(s)					
Spouse					
Children					

The questions on this form have been completed by me and accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility throughout the course of any future recommended treatment to inform this doctor's office of any changes in my medical status. I also authorize the healthcare staff of this office to perform any necessary services I may need today and in the future.

SIGNATURE of Patient, Parent or Guardian: **X**________________________________ Date: _____/_____/______

Provider APN/MD Signature: ______________________________________ Date: ______/______/______

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Patient Informed Consent to Examination & Treatment

To the Patient:
You understand that consultation, examination and any diagnostic testing will help determine if you are candidate for treatment and what types of treatment, if any, are recommended. You understand that treatment will not begin until all your questions and concerns have been answered to your satisfaction. You have a right as a patient to be informed about your condition, the recommended treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether to undergo the treatment or not. This information is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedures and/or treatment.

Consent for Medical Evaluation and Treatment:
I, with my signature below, authorize 360 Integrated Medical Center and/or Back to Health Wellness Center, it's healthcare providers, and any employee working under the direction of the Doctor/Nurse Practitioner, to provide medical services for me, or to this patient for which I am the parent or legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include, but not limited to, preventative, diagnostic, nutritional, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for coordination of care and treatment. I realize that doctors do not heal or treat any specific condition, but that the goal of holistic health is to strengthen the patient's body in order to heal themselves.

Consent for Chiropractic Evaluation and Treatment:
I have been advised that chiropractic care, like all forms of health care, carries some risk. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which is suggested to occur at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at 360 Integrated Medical Center and/or Back to Health Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to examination and treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Name Printed: ____ Date of Birth: _____/_____/_____

Patient, Parent or Guardian Signature: **X**_________________________________ Date: _____/_____/_____

Witness Initials: ___________

FEMALE PATIENTS ONLY:

Regarding X-Rays/Imaging Studies and Procedures: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, see your case manager for further explanation.*

- ❑ I am aware of when I am most likely to become pregnant, and to the best of my knowledge, **I AM NOT PREGNANT**, nor is pregnancy suspected or confirmed at this time. I consent to X-rays if the doctor/nurse practitioner deems them necessary for evaluation of my condition.

The first day of my last menstrual cycle (period) was on: (date) ______/______/______

By my signature below, I am acknowledging that the doctor, nurse practitioner, and/or staff member discussed with me the potentially hazardous effects of certain in office procedures, such as X-rays, that may cause ionization to an unborn child. I have conveyed my understanding of these risks and documented above my non-pregnancy condition as it relates to X-ray examination the doctor/nurse practitioner may have deemed necessary in my case.

Patient Name: ____ Date of Birth: ______/______/______

Patient/Guardian Signature: ____ Date: ______/______/______

Witness Initials: ___________

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Acknowledgments, Agreements and Authorizations

Patient Acknowledgment of Receipt of HIPAA Notice of Privacy Practices and Consent for Use of PHI, Disclosure of Ownership Interest, and Statement of Patient Rights & Responsibilities

I acknowledge receipt of a copy of 360 Integrated Medical Center and/or Back to Health Wellness Center Privacy Notice, last updated 3/1/2019, as well as a Disclosure of Ownership Interest and Statement of Patient Rights & Responsibilities.

__________________ initials

Consent to Health Care Services / Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from 360 Integrated Medical Center and/or Back to Health Wellness Center. The Patient health care services will be provided by and overseen by licensed, treating healthcare providers. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by 360 Integrated Medical Center. Medical, nursing, technicians, assistants and other health care personnel who are in training may also participate in the Patient's care as part of their education.

__________________ initials

Payment Guarantee / Assignment of Benefits

In consideration of the services provided by 360 Integrated Medical Center and/or Back to Health Wellness Center (hereafter, "the Clinics"), Provider to Patient, you agree to; 1) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); 2) irrevocably assign and transfer to the Clinics, all right, title and interest to medical insurance reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to the Clinics. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

__________________ initials

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance likely does not pay for all of your healthcare costs. Your insurance policy will only cover services that it deems "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care ($55-65 per visit), nutritional supplements, therapeutic modalities used for maintenance ($30), rehabilitation therapy ($50 per unit), regenerative medicine, and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

__________________ initials

Patient Right to Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have the right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that 360 Integrated Medical Center and/or Back to Health Wellness Center do not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

__________________ initials

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by 360 Integrated Medical Center and/or Back to Health Wellness Center for safekeeping under its sole care and custody. 360 Integrated Medical Center and Back to Health Wellness Center is not responsible for lost or stolen items.

Patient Name Printed: ____ Date of Birth: _____/_____/_____

Signature of Patient, Parent or Guardian: ____________________________________ Date: _____/_____/_____

Witness Initials: __________

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Consent to Call, Email or Text Message for Appointment Reminders and Other Communication

We have the ability to call, email or text you, reminding you of your scheduled appointments in our office. Patients in our practice may be contacted via phone, text message or email to be reminded of an appointment, to obtain feedback on an experience within our office, to view and obtain your personal health information in a secure way, test results, and to provide general health reminders and office information. **YOUR INFORMATION WILL NEVER BE SOLD AND WILL ONLY BE USED FOR DIRECT COMMUNICATION BETWEEN OUR OFFICE AND YOU.**

1) I consent to receiving appointment reminders and other healthcare communications and information via phone from 360 Integrated Medical Center and/or Back to Health Wellness Center. By completing and providing the phone number information below, you consent to this phone call communication.

   Preferred Phone Number for VOICE COMMUNICATION: (________) _________ - _______________

2) I consent to receive text messages from 360 Integrated Medical Center and/or Back to Health Wellness Center and temporarily from Back to Health Wellness Center on my cell phone and any number you have set forwarding/transferring to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is. By completing and providing the phone number information below, you consent to this text communication.

   Preferred Phone Number for TEXT COMMUNICATION: (________) _________ - _______________

3) I consent to receive email messages from 360 Integrated Medical Center and/or Back to Health Wellness Center and temporarily from Back to Health Wellness Center for the reasons stated above. The email that I authorize to receive email messages for general health reminders, feedback, and office information is provided below. By providing the email information below, you consent to this email communication.

   Preferred email for EMAIL COMMUNICATION: ____

I understand that this request to receive phone calls, emails and/or text messages from our office to you will apply to all future appointment reminders, feedback, health information unless I request a change in writing. By signing below, you consent to the above approved communication methods.

Patient/Guardian Signature: ____ Date: ______/______/______

Authorized Representatives

Your privacy is of utmost importance to us. If you are over age 18, you are the only one our office is authorized to communicate with regarding any aspect of your care, including appointments, finances and billing. Please list anyone you are authorizing to obtain verbal medical information about you, including your spouse or anyone else you authorize. If you do not list anyone below, then you will remain the only one authorized for office to communicate.

Name of Authorized Representative	Initiated Date	Phone Number	Relationship to You	Discontinue Date
1.				
2.				
3.				
4.				

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HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. You understand and agree to allow this office to use your Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care.

For coordination of care purposes, and as clinically indicated, 360 Integrated Medical Center PC ("360 Medical Center") and Back to Health Wellness Center PC ("Back to Health Chiropractic") may share your protected health information between each other as needed. You may request restrictions on disclosures by notifying us of any requested restrictions in writing.

Disclosure of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment and/or the coordination of care.

You may inspect and receive copies of your records within 30 days of a written request to do so and at a cost-based fee for photocopying, postage and preparation.

You may request changes to your records which our practice has the right to accept for deny. We maintain a history of protected health information disclosures that is accessible to you upon written request.

During the course of treatment and in the future, we may contact you for appointment reminders, announcements, promotions, and to inform you about our practice and its staff.

Our office is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed in a clearly visible location in our office located in the HIPAA NOTICE on the front desk.

You may file a complaint about privacy violations by contacting Matthew Kirkham at 219-326-5100.

If you would like a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the acknowledgement below as well as consent on the Confidential Patient Case History form.

Disclosure of Ownership Interest

This disclosure is to inform you of the common ownership interest between 360 Integrated Medical Center PC ("360 Medical Center") and Back to Health Wellness Center PC ("Back to Health Chiropractic") – hereinafter referred to as "360 and BTH". Matthew C. Kirkham owns, operates and has a financial relationship in both 360 and BTH. You have the right to choose an alternative source of service provider other than 360 and BTH. Should you desire to do so, please contact either office and ask for a list of alternate practices and/or providers.

Acknowledgement of Receipt of Notice of Privacy Practices AND Acceptance of Ownership Disclosure.

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Statement of Patient Rights and Responsibilities

The staff of 360 Integrated Medical Center PC and Back to Health Wellness Center PC recognizes that you have rights while a patient receiving medical care in this office. In return, there are responsibilities for certain behavior on your part as the patient. This statement of rights and responsibilities is posted in our facility in at least one location that is used by all patients. Your rights and responsibilities include:

Patient Rights

- Patients have the **right** to be treated with dignity and respect.
- Patients have the **right** to fair treatment regardless of race, ethnicity, creed, age, religious belief, sexual orientation, gender, health status, disability, or source of payment for care.
- Patients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the **right** to share in developing their plan of care.
- Patients have the **right** to the delivery of services in a culturally competent manner.
- Patients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients have the **right** to information about provider work history and training.
- Patients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients have the **right** to know about advocacy and community groups, including whether an interpreter is available if he or she does not speak English.
- Patients have the **right** to freely file a complaint, grievance, or appeal, and to learn how to do so, without reprisal.
- Patients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

Patient Responsibilities

- Patients have the **responsibility** to treat those giving them care with dignity and respect.
- Patients have the **responsibility** to give providers the information they need in order to provide the best possible care.
- Patients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc.).
- Patients have the **responsibility** to ask their providers questions about their care.
- Patients have the **responsibility** to help develop and follow the agreed-upon treatment plan.
- Patients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the **responsibility** to let their providers know about their insurance coverage, and any changes to it.
- Patients have the **responsibility** to let their provider know about problems with paying fees.
- Patients have the **responsibility** not to take actions that could harm others.
- Patients have the **responsibility** to report fraud and abuse.
- Patients have the **responsibility** to openly report concerns about quality of care.
- Patients have the **right** and **responsibility** to understand and help develop plans and goals to improve their health.

Complaints

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Administrative Director, Matthew Kirkham at 360 Integrated Medical Center and Back to Health Wellness Center. Or you can call 219-326-5100. We want to provide you with excellent service, including answering your questions and responding to your concerns.

I have read and understand my rights and responsibilities.