PEDESTRIAN ACCIDENT CHECKLIST

_____ Complete all of the following paperwork as accurately and completely as possible. Make sure to include your adjustor's name and contact information and your attorney's name and contact information. Make sure to sign the bottom of pages 2, 3, 7, 8, 9, and 11. Page 10 should be completed and signed where indicated if you intend to utilize a medical lien during the course of your care.

_____ Obtain a copy of the police report pertaining to the accident and bring it with you to your first appointment, if applicable.

_____ Contact the liable automobile insurance carrier and obtain a medical claim number for your case, if you have not already done so. **Make sure to get a <u>medical</u> claim number and not just an accident claim number, as they are two separate things.**

_____ Make sure to bring your health insurance card, if you have health insurance.

_____ Make copies of any additional paperwork pertaining to the accident that you may have and bring these with you to your first appointment. This includes items such as any tickets that were issued, the results of any diagnostic tests (including any x-ray, CAT scan, or MRI CD's you have been given), any doctor's notes or orders, and any correspondence from your auto insurance company or from the liable auto insurance company.

_____ Please keep page 12 for your records.

_____ Please arrive at least 10 minutes prior to your scheduled appointment time for your first visit.

Heritage Health Inc.
7555 E. Arapahoe Rd, Suite 2, Centennial, CO 80112
Phone: (303) 694-1245 Fax: (303) 694-1254

Office Use Only			
DR:	TN	PM	MS
Dxl		Dx2	
Dx3		Dx4	

Confidential Patient Information

Patient's Full Name: ____ Date: _____/_____/________

Home Phone: ___________________________ Cell Phone: ___________________

Mailing Address: _____________________________ City: ______________ State: ______ Zip: ___________

E-Mail:____ Male Female Age: ________

Your email will be used only for office updates and newsletters (it will not be sold or distributed for any other purpose)

Date of Birth: _____/____/________

Occupation: _______________ Hours/Week____ Employer: _______________Business Phone: ____________

Spouse's Name: ____________________ Employer: _____________ Business Phone: __________________

Emergency Contact: ____________________ Relationship: _________________ Phone: ________________

Emergency Contact Address: _______________________ City: _____________ State: ______ Zip: _________

How did you hear about our office? ________________ If referred, by whom? ________________________

Insurance Information

Do you have health insurance? Y/N Insurance Company Name: _______________________________________

Is Today's Visit due to a Pedestrian/Auto Accident: Y / N

Which best describes your health care goals:

______ Pain relief only (not interested in correction of problem)
______ Would like to find the cause of this problem and have it improved or corrected
______ Wellness / preventative care - just want to stay well and be at optimal health.

*There may be some things that your insurance company does not cover, but we have many reasonable and affordable payment options. If you have a problem that we can help, and we decide to accept your case, are you willing to pay out of pocket to reach your health care goals? _____ Yes _____ No

______________________________ ______________________________ __________
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date

ACCIDENT REPORT

At fault driver's Auto Insurance Company (if applicable):____
Phone: ______________________________

Medical Claim Number: ____________________________________
Adjustor's Name:____ Adjustor's Phone Number:_____________
Attorney's Name: ____ Attorney's Phone Number: ____________

Date of Accident: _______________ Time of Accident:______________
Major intersection/road or other location where accident occurred: _____________________________________
____

Please describe what happened in the accident (include details about your location and surroundings, the vehicle's direction of travel, direction of impact (i.e. hit head on, hit on side of your body, etc.), and any information about what happened to you after the impact:____
____
____
____

Were you (circle which one applies): bracing for the impact or surprised by the impact
Did you lose consciousness? Y / N If yes, for how long? ______________________________
Did you go to the hospital after the accident? Y / N
If yes, how were you taken there, which hospital/ER did you go to, what treatments or tests did you receive, and what were you told was wrong? ____
____
____

Have you seen any other doctors or health care providers since the accident? Y / N
If yes, who did you see, what treatments, tests, or medications did you receive, and what were you told was wrong with you? ____
____
____

Have you returned to work since the accident? Y / N
If yes, when did you return and to what kind of work? ____
____

If no, please state when you discontinued doing your regular work, what you are doing now for work, if anything, and when you started? ____
____

Have you had any previous accidents? Y / N
If yes, when did the previous accident occur, how were you injured, what treatments did you receive, and what problems, if any, do you still have a result of these accidents?____
____

_________________________________ _____________________________ ___________
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date

Chief complaint: ____

After the accident, when did these symptoms start? (i.e. immediately, 2 hours after, 2 days after, etc.)

____

Since Accident, has it gotten: Worse / Better / Same

Did you have the same or similar symptoms prior to the accident? Y / N

If yes, please describe: ____

____

Secondary or related complaint, if any: ____

After the accident, when did these symptoms start? (i.e. immediately, 2 hours after, 2 days after, etc.)

____

Since Accident, has it gotten: Worse / Better / Same

Did you have the same or similar symptoms prior to the accident? Y / N

If yes, please describe: ____

____

Other complaints, if any:____

After the accident, when did these symptoms start? (i.e. immediately, 2 hours after, 2 days after, etc.)

____

Since Accident, has it gotten: Worse / Better / Same

Did you have the same or similar symptoms prior to the accident? Y / N

If yes, please describe: ____

____

Concurrent Health Care:

Are you currently receiving treatment for this problem? Y / N If yes, with whom and what is being done?

____

____

PLEASE ANSWER THE FOLLOWING QUESTIONS
TO HELP EXPLAIN THE PROBLEM:

(Front) (Left) (Right) (Back)

Please Mark Areas of Pain using these Codes

X = Pain	=== = Radiating Pain
O = Sharp/Shooting	# = Numbness
+ = Dull/Ache	* = Tingling

SEVERITY OF PAIN:

List region of pain and circle the number which represents the intensity of your pain.

1. Chief Complaint: 0 1 2 3 4 5 6 7 8 9 10 (No Pain — Severe)
2. Secondary Complaint, if any: 0 1 2 3 4 5 6 7 8 9 10 (No Pain — Severe)
3. Other Complaint, if any: 0 1 2 3 4 5 6 7 8 9 10 (No Pain — Severe)

YOUR CHIEF COMPLAINT:

Describe the quality of the chief complaint/pain (circle):

Sharp / Shooting   Dull / Aching   Burning
Tingling   Numbness   Stabbing
Radiating   Throbbing   Localized
Other: ____________________

Does any of the following make your chief complaint worse? (circle):

Lifting   Bending   Pushing   Pulling
Coughing   Sneezing   Bowel Movement
Driving   Sitting   Working   Walking
Prolonged Standing   Twisting   Home Activities
Other: _________________________

How often are you aware of the chief complaint:

____ Intermittent (less than 25% of time when awake)
____ Occasional (25 - 50% of time when awake)
____ Frequent (50 - 75% of time when awake)
____ Constant (75 – 100% of time when awake)

Does any of the following make your chief complaint better? (circle):

Rest   Laying down   Sitting
Walking   Exercise   Moving About
Heat / Ice   Stretching   Medications
Massage   Treatments   Nothing
Other:___________________________

Does your chief complaint interfere with your daily activities:

____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities)
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your chief complaint? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

____
____
____

YOUR SECONDARY/RELATED COMPLAINT, if any:

Describe the quality of the secondary complaint: (circle):

Sharp / Shooting   Dull / Aching   Burning
Tingling   Numbness   Stabbing
Radiating   Throbbing   Localized
Other: ____________________

Does any of the following make your secondary complaint worse? (circle):

Lifting   Bending   Pushing   Pulling
Coughing   Sneezing   Bowel Movement
Driving   Sitting   Working   Walking
Prolonged Standing   Twisting   Home Activities
Other: _________________________

How often are you aware of the secondary complaint: (circle):

____ Intermittent (less than 25% of time when awake)
____ Occasional (25 - 50% of time when awake)
____ Frequent (50 - 75% of time when awake)
____ Constant (75 – 100% of time when awake)

Does any of the following make your secondary complaint better? (circle):

Rest   Laying down   Sitting
Walking   Exercise   Moving About
Heat / Ice   Stretching   Medications
Massage   Treatments   Nothing
Other:___________________________

Does your secondary complaint interfere with your daily activities:

____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities)
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your secondary complaint? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

____
____
____

OTHER COMPLAINTS, if any:

Describe the quality of any other complaints (circle):

Sharp / Shooting Dull / Aching Burning
Tingling Numbness Stabbing
Radiating Throbbing Localized
Other: ______________________

Does any of the following make your other complaints worse? (circle):

Lifting Bending Pushing Pulling
Coughing Sneezing Bowel Movement
Driving Sitting Working Walking
Prolonged Standing Twisting Home Activities
Other: ___________________________

How often are you aware of any other complaints:

____ Intermittent (less than 25% of time when awake)
____ Occasional (25 - 50% of time when awake)
____ Frequent (50 - 75% of time when awake)
____ Constant (75 – 100% of time when awake)

Does any of the following make your other complaints better? (circle):

Rest Laying down Sitting
Walking Exercise Moving About
Heat / Ice Stretching Medications
Massage Treatments Nothing
Other:_____________________________

Do your other complaints interfere with your daily activities:

____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities)
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your other complaints? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

____
____
____

Present & Past Health, Social and Family History

1. Have you **ever** had any **major illness, injuries, broken bones, hospitalizations, or surgeries**? Y / N
If yes, list them, circling all that were the result of the accident:

____
____
____

2. Is there any history of significant family health problems? If yes, please list them:

____
____
____
____

3. Weight _____________lbs. Have you recently lost or gained a large amount of weight? Y / N
Height _____________

4. Do you exercise regularly? Y / N If yes, how many hours a week and what activities: __________________

____
____

5. Do you smoke? Y / N If yes, how many packs/day? ______________________________________

6. Do you drink alcohol? None Occasionally Light Moderate Heavy

7. Circle any conditions you have had:

AIDS / HIV	Ear Ringing	Poor Circulation
Allergies	Epilepsy	Prostate Problems
Anxiety / Depression	Headache / Migraine	Rheumatoid Arthritis
Arm/shoulder pain	Heart Disease	Sciatica
Arthritis	Herniated Disc	Seizures
Asthma	High blood pressure	Shingles
Bladder Problems	Insomnia	Sinus Infections
Cancer	Irregular Cycle	Stroke
Chronic Fatigue	Kidney Problems	Thyroid Problems
Deafness	Leg Pain	TMJ
Diabetes	Low back pain	Venereal disease
Digestion Problems	Neck pain	Vertigo/Dizziness
Earache	Osteoporosis	Other: ____________________

8. Have you had any diagnostic imaging (i.e. X-RAYS, MRI, CT scan, Bone Scan, etc.) since the accident?
Y / N If yes, which tests did you have done and what were the results? ______________________________
____

9. Have you had any diagnostic imaging (i.e. X-RAYS, MRI, CT scan, Bone Scan, etc.) in the last 5 years?
Y / N If yes, which tests did you have done and what were the results? ______________________________
____

10. Have you detected any possible relationship between your current complaints and any of the following (circle)?
Muscle Weakness Bowel / Bladder problems Digestion Cardiac / Respiratory
Other: ______________________

11. Have you tried any self-treatment or taken any medication (over the counter or prescription): Y / N
If yes, explain the type of self-treatment and/or medication and the dosage: ______________________________
____
____
____

12. Have you had any previous Chiropractic/Physical Therapy care since your accident? Y / N
If Yes, who did you see and what treatments were performed?______________________________
____
____

13. Have you had any previous Chiropractic/Physical Therapy care prior to your accident? Y / N
If Yes, who did you see, what treatments were performed, and what problems were you receiving care for?
____
____

14. Are you currently pregnant or trying to become pregnant? Y / N / Not Sure

______________________________ ______________________________ __________
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date

PATIENT PAYMENT OPTIONS

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care in our office (if you are accepted as a patient), and you may choose the plan which best fits your needs. Please read carefully and choose the plan you prefer. This information will enable us to better serve you and help avoid any misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and well being, and we will do our best to help you!

PLAN l: PROMPT PAY- Fees are to be paid at the time services are rendered (every visit), unless special arrangements have been made in advance. We accept Cash, Check, Visa or MasterCard. Care Credit plans are also available, offering 6, 12, and 18 month options with no interest. If you have additional questions regarding Care Credit, please inquire with a Heritage Health staff member.

PLAN 2: MEDICAL LIEN – On a case-by-case basis, we may accept your case using a medical lien. This option is commonly used when patients do not have med pay coverage, have exhausted their med pay coverage, or are anticipated to require more treatment than will be covered by med pay. When you sign a medical lien form with our office, you not be required to pay for your care until your treatment is finished and an insurance settlement has been reached. A medical lien form directs your attorney or your insurance adjustor to withhold the amount due for your treatment from any final settlement that is reached, and to make direct payment to our office for all outstanding bills. If you are accepted as a patient on a medical lien basis, you will need to supply us with the police report, liable parties' insurance information, your accident claim number, your accident adjustor's contact information, and attorney information if applicable. Until the necessary information is gathered and verified, or you have retained an attorney, you will be required to pay for your care. If we choose to accept your case on a medical lien, we will bill the liable insurance company directly. In the event that you or your attorney achieve a settlement, then we expect payment to be made immediately.

If you are released from care or non-compliant with the medical recommendations, the entire account balance is due within 90 days. **You are ultimately responsible for the payment of all services on your account, regardless of whether you are awarded a settlement or not**. If payment on your account is not made, the balance will be submitted to a collection agency.

PLAN 3: HEALTH INSURANCE - If you have health insurance that covers Heritage Health Services and we are willing to accept your insurance, we can bill your health insurance directly if you would like us to. Please realize that this should be used as a last option because many health insurance companies may deny bills related to accident injuries. If we submit bills to your health insurance company and the charges are denied, you will be responsible for all unpaid charges. Please provide us with your current health insurance card, on or before your second visit. Until we have the completed, correct, and necessary information regarding coverage, you will be required to pay for your care. Most patients are required to pay a co-pay/co-insurance in addition to their yearly deductible. In the event that a payment should come to you, you are expected to bring the endorsed check to us along with the EOB's. The contracted insurance plan is yours, not ours; therefore you are always responsible for your account with us. If you become inactive by discontinuing your care, your account balance is due immediately. If payment on your account is not made, the balance will be submitted to a collection agency.

Patient or Legal Guardian Printed Name	Patient or Legal Guardian Signature	Date

Authorization to Release Information

If I am accepted as a patient, I authorize this healthcare facility to release all information related to the care I receive to my primary care physician, insurance company, third party payor, attorney, or their designee, as may be necessary for the coordination of care, payment of my bill, determining benefits, or for quality review.

Privacy and Confidentiality

I understand that this healthcare facility is making extensive efforts to protect my personal privacy and information. I understand that there are some treatments and procedures that are not in a private setting, such as therapy tables and exercise rehabilitation. If I am uncomfortable with that setting, I will notify the staff and they will try to accommodate me as much as possible. I also give permission for the office to leave messages regarding future appointments and information related to my care. A Federal and State law (HIPPA) requires all healthcare facilities to adhere to their policies regarding the release and disclosure of medical records. Records and x-rays are the property of this facility. Copies of records may be received only by authorization of the patient or guardian, request must be in writing, and charges for those copies follow the usual/customary costs. 7-10 business days is required to process request. I have received a copy of the privacy protection policy.

Authorization for Examination, Diagnostic Testing, and Treatment

If, after consultation and deemed appropriate, I authorize the performance of examination, diagnostic tests, procedures, and treatment deemed necessary by personnel in this office regarding my care. Necessary procedures will be discussed with the doctor/therapist on a case by case basis. I give the office staff permission to use their best clinical judgment regarding what is necessary to handle my case. I understand that occasionally it may be necessary for another doctor/therapist to treat me.

I understand that the doctor/therapist will explain the risks/benefits, the prognosis of my condition, and refer me to another provider if needed. I understand that it may not be possible for every risk factor to be explained to me. I expect the doctor/therapist to use their best judgment in the management of my care. I also understand that the intent of this facility is to facilitate healthy body function relating to musculoskeletal conditions and some individuals may need another medical provider to diagnosis and treat certain diseases.

Assignment of Benefits

I assign to Heritage Health Inc. and all affiliates of Heritage Health Inc. all benefits payable to me for my care. If I ask this facility to handle my insurance claims for me, I authorize this healthcare facility to be paid directly by the insurance company or other third party payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

I guarantee payment of all charges incurred for evaluation and treatment in accordance with the rates and terms of this healthcare facility. I understand that this agreement will start once I am accepted as a patient and my care plan and responsibilities are discussed.

Payment for all services is required on the same day and may be paid by cash, check, VISA, MasterCard, and Care Credit unless other arrangements have been previously made. If we are submitting claims for your insurance to pay, then your co-insurance and payment toward your annual deductible is also required at the time of service.

We are happy to file claims for you if appropriate. However, disputes regarding coverage, benefits, payments, etc. are strictly between the patient and the insurance company. Most insurance claims involve delay before we receive payment. Please keep in mind that we can't guarantee payment from the insurance company, your insurance is your responsibility, and insurance company contracts are between the company and the insured individual(s). We may need your help to collect payment for your claims. Ultimately, you are responsible for payment of any services.

Method of Payment for charges:

_____ Cash _____ Credit Card _____ Credit Card on File
_____ Check _____Med Pay
_____ Medical Lien _____ Health Insurance

I certify that I understand the above office policies and agree to abide by the same.

____________________________ ____________________________ __________

Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date

DOCTOR'S LIEN

HERITAGE HEALTH
7555 East Arapahoe Road, Suite 2
Centennial, Colorado 80112
(303) 694-1245; (303) 694-1254 Fax

Patient Name: ____
Adjustor's Name: ____
Attorney's Name:____
Date of Accident: ____
Medical Claim #: ____

I hereby authorize Heritage Health to furnish you with my complete medical records and a full report concerning case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to the above-referenced accident.

I hereby irrevocably authorize and direct you, to pay directly to Heritage Health, such sums as may be due and owing for medical services rendered to me by reason of the above referenced accident, and to withhold such sums from any settlement, judgment, award, or verdicts as may be necessary to fully and completely compensate Heritage Health.

I hereby give a lien on my claim arising out of the above-referenced accident to said facility against any and all proceeds of any settlement, claim, judgment, or verdict for any outstanding balances owed at the time of distribution of funds from any settlement, claim, judgment, or verdict arising out of the above-referenced accident.

I fully understand that I am directly responsible to Heritage Health for all medical bills submitted by them for services rendered to me and that this agreement is solely for Heritage Health's additional protection and in consideration of their awaiting payment.

I further understand that such payment is not contingent on any settlement, judgment, award, or verdict by which I may eventually recover.

_____________________________ _____________________________ __________
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date

FOR OFFICE USE ONLY (YOUR ADJUSTOR OR ATTORNEY WILL COMPLETE THE REMAINDER OF THIS FORM)

The undersigned representative agrees to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the above named provider and to issue such sums withheld to the above named provider directly.

________ ____________________________ ____________________________
Date Adjustor's Name Adjustor's Signature

________ ____________________________ ____________________________
Date Attorney's Name Attorney's Signature

Please read and Sign the below form before examination and treatment

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative non-invasive treatment of the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Disc/Nerve Injury: I understand that, in isolated cases, disc and/or nerve injury/irritation may occur as the result of treatment. In cases where disc or nerve tissue involvement is suspected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage, including stroke, is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn occurs, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor/therapist.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, physical therapy, and acupuncture is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor/therapist and such other persons of the doctor's/therapist's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, and home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: I understand that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar tissue/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic/physical therapy/acupuncture treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

______________________________ ______________________________ __________

Patient or Legal Guardian Printed Name   Patient or Legal Guardian Signature   Date

Privacy Protection Policy

This page describes how medical information about Heritage Health's patients may be used and disclosed and about how you can access this information. If, after reviewing this information, you have any questions, please contact front desk.

Heritage Health is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of the legal duties and privacy practices regarding such protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify a family member, or anyone else responsible for your care, in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that Heritage Health is sold or merged with another organization, your health information/record will become the property of the new owner.

You're Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Heritage Health amend your protected health information.
- You have a right to receive an accounting of disclosures of your protected health information made by Heritage Health.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.