TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column and/or of an extremity which causes alteration of nerve function and interference to the nervous system. This results in a lessening of the body's innate ability to express its maximum health potential. Subluxation may also result in pain, dysfunction, or may be entirely asymptomatic.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interferences to the nervous system which in turn aides in the body's ability to heal itself. Our only method of correction is specific chiropractic adjusting of subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted r required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographics information, that may identify you that relates to your past, present or future physical or mental health or condition and related health care service.

1. Use and Disclosures of Protected Health Information

We Are Required By Law To:

- **Protect the privacy of your personal information**
- **Provide this Notice explaining our duties and privacy practices regarding your personal information**
- **Notify you following a breach of your unsecured personal information and**
- **Abide by the terms of this Notice**

Use and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health play to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training for medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight : Abuse or Neglect: Food and Drug Administration requirements : Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Business Associates
We may disclose your personal information to our Business Associates. These are entities or individuals that are not employed by us that perform health care operations or payment activities on behalf which requires that the Business Associate create, receive, maintain, or transmit your personal information. We must have contracts with our business associates that required them to maintain the confidentiality of your personal information.

Individuals Involved in Your Care or Payment for Your Care
We may disclose personal information about you to a family member or other individuals who are directly involved in your care or payment for your care, even after your death.

Public Health and Safety
We may disclose personal information about you to the extent necessary to avert a serious and imminent threat to your health or safety or the health of safety of others.

Legal Proceedings
We may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement
We may disclose your personal information to law enforcement officials if we receive a court order, warrant, grand jury subpoena or an inquiry for purposes of identifying or location a suspect, fugitive, material witness or missing person. If you are an inmate, we may disclose your personal information to correctional institutions as allowed by law.

Military and National Security
Under certain circumstances, we may disclose to military authorities the personal information of armed forces personnel. We may also disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence and other nation security activities.

Sales and Marketing
We will not sell your personal information or use or disclose it for marketing purpose without first obtaining your written authorization to do so.

Restriction Request
You have the right to request a restriction or limitation on the personal information we use or disclose about you for treatment, payment and health care operations activities or disclosures to individuals involved in your care.

Other permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

HIPAA Notice of Privacy Practices

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction apply.

Your physician is not required to agree to a restriction that you mat request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have an agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the term of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **September 23rd, 2013.**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

_____ _____

Patient Name (Please Print) Date

_____

Parent/Guardian or Patient's legal representative (Please Print)

_____

Signature

Assignment of Benefits

Date: ___/___/_____

PROVIDER INFORMATION:	**PLAN MEMBER INFORMATION:**
Moore Chiropractic, PLLC 221 Kenyon St. NW, Suite 201 Olympia, WA, 98502 360-352-0211 – Phone Number 360-352-6226 – Fax Number thedrsmoore@moorechiropractic.com	[Plan Member's Name] [Address] [City, State Zip Code] [Plan Member ID #] [Group ID #] [Phone Number]

AUTHORIZATION

I hereby understand that the fees that are listed in this claim may not be covered by or may indeed exceed all of my plan benefits. I also understand that I alone am financially responsible to the service provider for all of the cost that is associated with this claim and I do hereby assign my benefits payable from this claim to the above named service provider and I authorized payment directly to them.

I fully understand that the Benefit Plan Sponsor has the right to modify the assignment privileges for specific benefits, categories and or service provider categories.

I hereby certify that all of the information that is provided in connection with this claim is true, complete and accurate. I authorize any doctor, medical practitioner, or any other person that may have any records, knowledge or information regarding this claim to release such information and to exchange information with any of the named parties where the exchange is necessary for the proper processing of the claim. All photo copies of this signed Assignment of Benefits shall be as valid as the original.

Plan Member's Signature: _____Date: ___/___/_____