Back In Harmony Chiropractic and Wellness Center, LLC

6115 Stirling Rd, Suite 205 • Davie, FL 33314 • Tel: 954-604-5384 • Fax: 954-440-2471

CONFIDENTIAL PATIENT INFORMATION

Name:_____ Date: _____

Please describe your major complaints/symptoms: _____
_____
_____

Is your current problem the result of: Auto Accident? Work Accident? Slip & Fall?

When did this start? _____

What caused the pain? _____

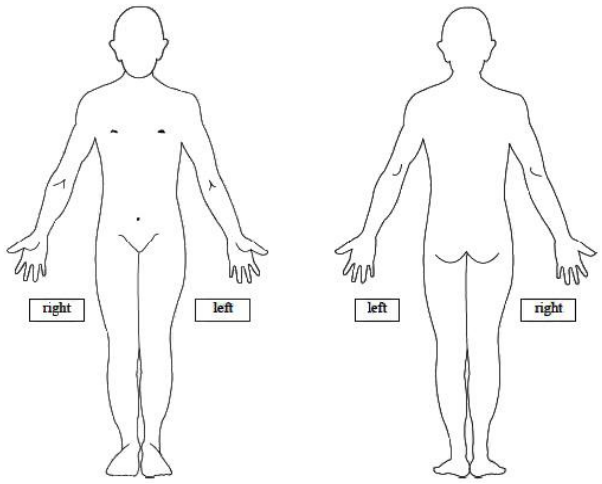
How often are your symptoms present?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms:
☐ Sharp/Stabbing ☐ Burning ☐ Throbbing ☐ Shooting
☐ Tingling ☐ Stiffness ☐ Dull ☐ Numbness ☐ Soreness
☐ Aches ☐ Weakness ☐ Swelling ☐ Heavy Pressure
☐ Other (please describe)_____

Please rate the severity of your pain:
☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable

Does this pain travel to any other area? If yes, where? _____
_____

Please mark the area of discomfort below.
Pain XXXX Numbness OOOO Pins&Needles////
Burning ++++ Aching - - - - Stabbing VVVV



What makes this pain better? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Heat ☐ Ice ☐ Massage ☐ Pain Killers Other

What makes this pain worse? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Heat ☐ Ice ☐ Massage ☐ Other

Since it began, is your problem: ☐ Improving ☐ Getting Worse ☐ No Change

Does this interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Describe your job requirements: ☐ Mainly Sitting ☐ Light Labor ☐ Heavy Labor ☐ Standing

Have you lost any work? ☐ Yes ☐ No Day and date you last worked _____

Have you had: ☐ pain that wakes you out of a sound sleep?
☐ any changes in bowel or bladder habits?
☐ night sweats?
☐ lost or gained weight in the past year?

What else have you done to treat this pain? _____

Have you ever had chiropractic care before? ☐ Yes ☐ No Dr's name_____
Last adjustment _____Were the results satisfactory? ☐ Yes ☐ No ☐ N/A

Have you ever had this condition before or a similar condition? ☐ Yes ☐ No When? _____

Date of last:
Physical Exam _____ Spinal X-Ray _____ Blood Test _____
MRI, CT, Ultrasound, Bone Scan _____Chest X-Ray _____ Urine Test _____

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REVIEW OF SYSTEMS

Mark if you currently have any of the following conditions

EYES/ EARS/ NOSE/THROAT
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Hearing difficulty
- ☐ Ringing in ears
- ☐ Ear aches
- ☐ Ear infections
- ☐ Ear discharge
- ☐ Itchy ears
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Chronic cough
- ☐ Sputum
- ☐ Often clear throat
- ☐ Sore throat
- ☐ Canker sores

SKIN
- ☐ Varicose Veins
- ☐ Hives, rashes
- ☐ Flushing, hot flashes
- ☐ Dermatitis/Eczema
- ☐ Bruise easily

RESPIRATORY
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Chest pains
- ☐ Swelling of ankles

GASTROINTESTINAL
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Indigestion
- ☐ Bloated feeling
- ☐ Belching or passing gas
- ☐ Gall bladder trouble
- ☐ Ulcers
- ☐ Liver trouble
- ☐ Abdominal pain

GENITO-URINARY
- ☐ Bedwetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney stones
- ☐ Incontinence
- ☐ Menstrual Pain
- ☐ Excessive Menstrual Flow
- ☐ Irregular Cycle

HEMATOPOIETIC
- ☐ Pallor
- ☐ Bleeding disorders
- ☐ Jaundice
- ☐ Anemia

JOINTS & MUSCLES
- ☐ Arthritis
- ☐ Joint pains or aches
- ☐ Muscle pains or aches
- ☐ Stiffness
- ☐ Swollen, tender joints

ENDOCRINE
- ☐ Excessive Thirst
- ☐ Thyroid Trouble
- ☐ Excessive Sweating
- ☐ Heat Intolerance

EMOTIONS
- ☐ Mood swings
- ☐ Anxiety, fear
- ☐ Irritability, anger
- ☐ Depression
- ☐ Aggressiveness
- ☐ Nervousness

GENERAL
- ☐ Headaches
- ☐ Weakness
- ☐ Fatigue
- ☐ Restlessness
- ☐ Fainting
- ☐ Dizziness
- ☐ Insomnia
- ☐ Epilepsy
- ☐ Poor memory
- ☐ Confusion
- ☐ Poor concentration
- ☐ Night sweats

OTHER
- ☐ Frequent illnesses
- ☐ Diabetes
- ☐ Tumors/lumps
- ☐ Cancer
- ☐ AIDS/HIV
- ☐ Appendicitis

FAMILY HISTORY:
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Other _____

_____

SOCIAL HISTORY:
- ☐ Smoking - Packs/Day _____
- ☐ Alcohol - Drinks/Week _____
- ☐ Caffeine - Cups/Day _____

EXERCISE:
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

STRESS:
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ High

MEDICATIONS/ VITAMINS/ SUPPLEMENTS

ALLERGIES:

Injuries/Surgeries you have had:	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature_____ Date _____

AUTHORIZATIONS AND RELEASES

Back In Harmony Chiropractic and Wellness Center, LLC • 6115 Stirling Rd, Suite 205, Davie, FL 33314 • 954-604-5384

CONSENT FOR TREATMENT

I voluntarily consent to the performance of chiropractic treatment and any other associated procedures, including the performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

I understand, as with any health care procedures, that there are some risks to treatment, including but not limited to: fractures, disc injuries, dislocations, muscle strains and strokes. I do not expect the chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the chiropractor to exercise judgement during the course of the procedure which he/she feels at the time, based on the facts then known, that are in my best interest. I also understand that specific results are not guaranteed.

I have read, or have had read to me, the above consent. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature _____ Date _____ Witness _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Patient Signature _____ Date _____ Witness _____

AUTHORIZATION FOR RELEASE OF RECORDS AND X-RAYS

Pursuant to appropriate statues and rules. I hereby authorize and request that you release and forward copies of any and all health records in your possession, including x-rays to:

_____
Physician

_____
Address

_____
City State Zip

Patient Signature _____ Date _____ Witness _____

VERIFICATION OF NON-PREGNANCY (FEMALE PATIENTS ONLY)

By my signature on this form, I do hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time. I further agree and release Dr. Chong and her staff from any responsibility for injury or complication to myself or my fetus should I be pregnant on this date.

I further agree to notify this office in writing during the course of my treatment should I become pregnant.

Patient Signature _____ Date _____ Witness _____

OFFICE FINANCIAL POLICY

Back In Harmony Chiropractic and Wellness Center, LLC • 6115 Stirling Rd, Suite 205, Davie, FL 33314 • 954-604-5384

Professional Fee Schedule

Chiropractic Initial Consultation/Examination ..... $115 and up
X-Rays..... $50 and up
Chiropractic Office Visits..... $45 and up

Acupuncture Initial Consultation.....$115
Acupuncture treatments.....$70

All fees are standard and based on our professional association's guidelines for our geographic area.

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office, and you may choose the plan that best fits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help avoid 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.

(Check One)

( ) **PLAN #1 HEALTH INSURANCE:** If you have health insurance that covers Chiropractic care, we will bill your insurance directly and expect to be reimbursed by your insurance company. Please be aware that payment from your insurance company cannot be guaranteed, and benefits are not determined until your claim is processed. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. Our staff will collect any applicable deductible, co-payments, patient responsibilities and any charge for non-covered services from you at the time of service. In the event the check should come to you, you are expected to bring the check to us.

( ) **PLAN #2 CASH AGREEMENT:** This option is for those that do not have insurance or choose not to use their insurance. This is a fee-for-service option and full payment is due at the time services are rendered. We accept cash, check, Visa, Mastercard and Discover. If you do not have coverage for chiropractic care you may want to consider joining ChiroHealth USA, a Discounted Medical Plan Organization. Inquiries can be made at the front desk.

( ) **PLAN #3 CHIROHEALTH USA:** We have joined ChiroHealth USA to enable us to keep visits affordable for those that are uninsured or underinsured for chiropractic care. This is a Discounted Medical Health Plan which allows us to offer a discounted fee for non-covered services. Annual membership is $49 and covers you and your immediate family.

( ) **PLAN #4 "ON THE JOB" INJURY:** Worker's Compensation pays in full for chiropractic care. Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately. I understand that I am being treated under the assumption that this injury is work-related. In the event that this case proves not to be work-related or denied, then I am fully aware of the charges incurred to me and I am also aware that I am fully responsible for the charges.

( ) **PLAN #5 AUTO-INJURY:** We will bill your insurance directly after verification of coverage. Most patients have either Medical Payments coverage or an attorney or both. If you hire an attorney to represent you, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your lawsuit. **Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.**

We hope that this has answered any questions that you might have about our financial arrangements. If at any time you have further questions about your care, please do not hesitate to ask us.

I have read and understand the above terms.

Patient Signature: _____ Date: _____

WEI SHEEN CHONG, D.C.

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint WEI SHEEN CHONG, D.C., and any of its duly-authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said WEI SHEEN CHONG, D.C., which checks, drafts or money orders are made payable for services which have been made by WEI SHEEN CHONG, D.C., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows WEI SHEEN CHONG, D.C., or any of its agents, to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said WEI SHEEN CHONG, D.C. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to WEI SHEEN CHONG, D.C., or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by WEI SHEEN CHONG, D.C. but not to exceed the charges of those services, payable to and mailed directly to:

WEI SHEEN CHONG, D.C.
6115 Stirling Rd, Ste 205
Davie, FL 33314

Furthermore, I hereby IRREVOCABLY ASSIGN to WEI SHEEN CHONG, D.C., the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by WEI SHEEN CHONG, D.C..

IN WITNESS WHEREOF, the undersigned have hereunto set their hands, this ___day of_____, 20__.

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (Please Print)

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

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6115 Stirling Rd, Suite 205, Davie, FL 33314
Tel: 954 604 5384
Fax: 954 440 2471

LETTER OF PROTECTION

TO: ATTORNEY: _____ Patient: _____
_____ Date of Accident: _____
_____

I hereby authorize Dr. Wei Sheen Chong to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing her for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that this lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of her awaiting payment. I further understand that such payment is not contingent of any settlement, judgement or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor named above.

Attorney's Signature: _____ Date: _____

ATTORNEY: Please date, sign and return one copy to the doctor's office and retain one copy for your records.

NOTICE OF PRIVACY PRACTICES

Back In Harmony Chiropractic and Wellness Center, LLC • 6115 Stirling Rd, Ste 205, Davie, FL 33314 • 954-604-5384

PLEASE KEEP FOR YOUR RECORDS

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.

Back In Harmony Chiropractic and Wellness Center, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Uses 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, 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 to diagnose or treat you.
Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If you are covered by a medical plan, our office will bill the insurance company; the claim form will contain information that identifies you, your diagnosis, and the treatment you received.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of business associate, licensing, and conducting or arranging for other business activities. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this 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 or other health-related services that may be of benefit to you.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: 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.
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.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.
Change of Ownership: In the event that Back In Harmony Chiropractic and Wellness Center, LLC. is sold or merged with another organization, your health information/records will become the property of the new owner.

Your Health Information Rights:

- You have the right to inspect and copy your protected health information.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Back In Harmony Chiropractic and Wellness Center, LLC. is not required to agree to the restriction that you requested. If 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 a right to request that Back In Harmony Chiropractic and Wellness Center, LLC. amend your protected health information. Please be advised, however, that Back In Harmony Chiropractic and Wellness Center, LLC. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Back In Harmony Chiropractic and Wellness Center, LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices: We reserve the right to change the terms 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.

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.

Complaints: Complaints about your privacy rights can be made in writing to:

Attn: Office Manager
Back In Harmony Chiropractic and Wellness Center, LLC.
6115 Stirling Rd, Ste 205
Davie, FL 33314

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to the Department of Health and Human Services:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201