-- Auto Accident Information --

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Please complete this packet as completely and as accurately as your current condition allows. Where response choices are required, please use a check mark "√" to indicate the most appropriate answer. If a question does not apply to you, please write "N/A" (not applicable). If you are unsure about how to accurately answer a question, write a "?" next to it. Please PRINT all responses and ask for assistance if you have any questions.

Patient's Name: _____ Today's Date: _____ Date of Injury: _____

Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F Marital Status: _____ SS#: ___-__-____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (___) _____ Mobile Phone: (___) _____ Email Address: _____

Emergency Contact Name: _____ Emergency Phone: (___) _____

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

At the time of the collision, who was driving the vehicle you were in? ☐ I was ☐ The person indicated below was driving:

(Do Not Complete This Section If ***You*** Were the Driver) Driver's Name: _____

Driver's Address: _____ Driver's Phone: (___) _____

Was the vehicle registered to you? ☐ Yes ☐ No If not, who was it registered to? _____

Your seating position in the vehicle: ☐ Front Seat ☐ Back Seat / ☐ Left ☐ Right ☐ Center _____

Was anyone else in the vehicle with you at the time of the collision? ☐ Yes ☐ No If yes, identify all persons below:

	Name	*Relationship*	*Age*	*Injured?*
1.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
2.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
3.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
4.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure

Were you on the job at the time of the collision? ☐ Yes ☐ No If yes, was it reported to your employer? ☐ Yes ☐ No

Location of the accident: _____

What were the road and weather conditions like at the time? _____

Please describe, in detail, how the accident happened: _____

_____

_____

Please diagram the accident below:

Total number of vehicles involved in the collision: _____

Total number of impacts to your vehicle: _____

Side(s) of your vehicle impacted: _____

Were you wearing a lap & shoulder belt? ☐ Yes ☐ No

Was there a head restraint? ☐ Yes ☐ No

At impact, was head forward of head restraint? ☐ Yes ☐ No

At impact, was your head rotated? ☐ Yes ☐ No

At impact, was your torso rotated? ☐ Yes ☐ No

At impact, was your body leaning forward? ☐ Yes ☐ No

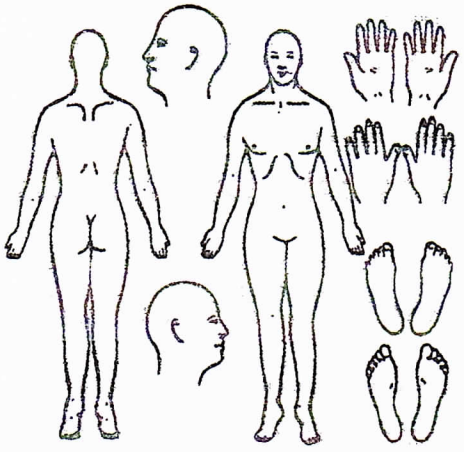
Did you anticipate the impact? ☐ Yes ☐ No

Estimated speed of YOUR vehicle at impact: _____ mph

Estimated speed of OTHER vehicle at impact: _____ mph

Did you strike anything within the vehicle? ☐ Yes ☐ No If yes, please identify the item struck in the vehicle from the list below. Also, please draw a line from the item impacted to the part of the body struck.

- ☐ Airbag
- ☐ Dashboard
- ☐ Windshield
- ☐ Steering wheel
- ☐ Gear selector
- ☐ Head restraint
- ☐ Inner door panel
- ☐ Ceiling
- ☐ Armrest
- ☐ _____
- ☐ _____



Comments

Did the seat you were in break and/or fall backwards from the impact? ☐ Yes ☐ No Explain: _____

Did any windows break in your vehicle? ☐ Yes ☐ No If yes, please identify: _____

Was there any "flying" glass from the impact? ☐ Yes ☐ No If yes, please identify: _____

Were there any: Cuts? ☐ Yes ☐ No / Bruises? ☐ Yes ☐ No / Abrasions? ☐ Yes ☐ No / Photos taken? ☐ Yes ☐ No

If yes, please describe: _____

_____

Make and model of the vehicle you were in: _____ Year: _____

Describe any damage done to the vehicle you were in: _____

_____

_____

_____ Photos taken? ☐ Yes ☐ No

Make and model of the other vehicle(s): _____ Year: _____

Describe any damage done to the other vehicle(s): _____

_____

_____

_____ Photos taken? ☐ Yes ☐ No

After impact, did you: lose consciousness at any time? ☐ Yes ☐ No _____

lose bowel or bladder control? ☐ Yes ☐ No _____

have facial numbness/speech problems? ☐ Yes ☐ No _____

extremity numbness/weakness? ☐ Yes ☐ No _____

Were you able to get out of the vehicle on your own? ☐ Yes ☐ No If not, who helped you? _____

If you were assisted out of your vehicle, describe how you were removed: _____

_____

Did you receive any first aid at the scene? ☐ Yes ☐ No If yes, by whom? _____

If applicable, what first aid was provided to you at the scene? _____

Who was called or came to the accident scene? ☐ Highway Patrol ☐ Local Police ☐ Sheriff ☐ Paramedics

☐ Ambulance ☐ Other _____

Was a report made? ☐ Yes ☐ No If yes, do you have a copy? ☐ Yes ☐ No ☐ Not yet, but I will provide it.

Did you go to the emergency room? ☐ Yes ☐ No Urgent care? ☐ Yes ☐ No Doctor's office? ☐ Yes ☐ No

If you answered "yes" to any of the above questions, please identify where you went and who attended you there: _____

What was done for you there?

Exam:	☐ Yes	☐ No	Pain medication:	☐ Yes	☐ No
X-ray:	☐ Yes	☐ No	Anti-inflammatories:	☐ Yes	☐ No
MRI:	☐ Yes	☐ No	Muscle relaxants:	☐ Yes	☐ No
CT:	☐ Yes	☐ No	Supports/Braces:	☐ Yes	☐ No

What diagnoses were you given? _____

Were you told to do anything by the attending doctor? ☐ Yes ☐ No If yes, please indentify: _____

Were you hospitalized at any time as a result of the injuries you sustained from the accident? ☐ Yes ☐ No If yes, please identify the name and location of the hospital, entry date, exit date, and the name of the treating doctor(s): _____

What was done for you at the hospital? _____

Describe symptoms:

Immediately after the accident: _____

Later that same day: _____

The next day: _____

Have you seen any other health care professional since the first day of the accident? ☐ Yes ☐ No If yes, please complete the section below: *(Begin with the person you saw first and proceed to the most recent.)*

Name	Title	Dates seen	What was done for you?

Please identify any other treatment for this injury (check all that apply): *(specify)*

- ☐ Heat
- ☐ Cold
- ☐ Rest
- ☐ Exercise
- ☐ Stretches
- ☐ Massage
- ☐ Other: _____
- ☐ Slept in different position
- ☐ Slept on a different surface
- ☐ Minimized motions of the head
- ☐ Minimized overhead work
- ☐ Minimized lifting
- ☐ Minimized sitting
- ☐ Restricted home activities: _____
- ☐ Restricted work activities: _____
- ☐ Continued prescription meds: _____
- ☐ Took over-the-counter meds: _____

Normal job duties: _____

Current job duties: _____

Have you missed any work and/or job opportunities as a result of your auto accident? ☐ Yes ☐ No Please identify: _____

Have you had any injury or significant illness ***since*** the auto injury? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you had any significant injury or illness, of any type, ***prior*** to the auto injury? ☐ Yes ☐ No If yes, what was the nature of the problem and when did it occur? _____

_____

_____

If professional care was rendered for the above prior injury or condition, how long were you treated, by whom, and what was done for you? Was it fully resolved? _____

_____

_____

Have you ever had any award of permanent disability/impairment for any prior condition/injury? ☐ Yes ☐ No If yes, please identify what the award was, when it was received, and for what condition/injury: _____

_____

Are you currently under any other doctor's care? ☐ Yes ☐ No If yes, who is the doctor and what is he/she treating you for? _____

_____

What medications, prescribed or not, are you currently taking to treat any condition or injury ***unrelated*** to your auto accident injuries? _____

_____

Have you ever served in the armed forces? ☐ Yes ☐ No If yes, what were the dates of service and what type of discharge did you receive? _____

Prior to this auto accident, have you ever been diagnosed as having any of the following? Circle *all* that apply.

Whiplash	Neck Sprain	Spondylolysis	Vertebral Fracture	Rheumatoid Arthritis
Scoliosis	Back Sprain	Facet Arthrosis	Metabolic Disorder	Ankylosing Spondylitis
Spondylosis	Osteoporosis	Disc Protrusion	Diabetes Type 1 or 2	Foraminal Encroachment
Fibromyalgia	Pagets Disease	Spinal Infection	Any Spinal Anomaly	Carpal Tunnel Syndrome
TMJ Problem	Spinal Stenosis	Spondylolisthesis	Extremity Dislocation	Degenerative Disc Disease

Comments: _____

_____

Before the auto accident, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you currently use tobacco products? ☐ Yes ☐ No If yes, how much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Did you have any recreational activities or hobbies before the accident? ☐ Yes ☐ No If yes, what were they and how often did you do them? _____

_____

Please provide any additional information you believe is important to your case: _____

_____

_____

_____

_____

Current Medical Complaints

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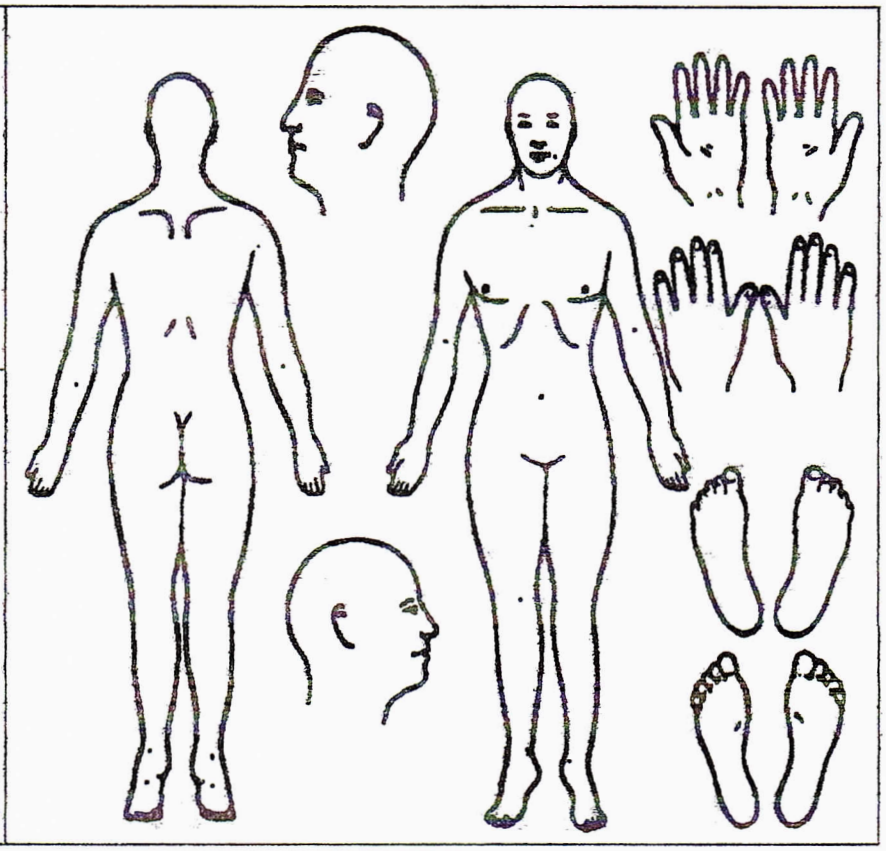
It is important to carefully identify your current complaints. Use the body diagram to identify the location and nature of your symptoms. **Please use the key below.**

+++ = sharp or stabbing
~~~ = burning
ooo = pins and needles
vvv = dull or aching
/// = numbness

-- Comments --



--- Circle the number of any and all symptoms that have appeared, even briefly, since the time of the auto collision.---

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol
25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose or chipped teeth
37. Tender muscles in front of the neck
38. Pain on swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell
42. Decreased ability to taste
43. Vision changes
44. Blood in the urine
45. Pain over one or both kidneys
46. Urinary problems
47. Loss of weight
48. Weight gain
49. Nightmares
50. Pain on inhaling deeply
51. Indigestion
52. Diarrhea
53. Constipation
54. Vomiting
55. Nervousness
56. Cramping
57. Knees buckling unexpectedly
58. Dropping things easily
59. Weakness in the arms or legs

Other Symptoms and/or Comments:

_____
_____
_____
_____
_____
_____

Please sign and date this 5-page form here: Signature: _____ ***Date:*** _____

CLAREMONT CHIROPRACTRIC
E. MARK WATERMAN, D.C.
5405 Arrow Hwy Ste. 104
Montclair, CA 91763
(909)670-2225

NOTICE OF DOCTOR'S LIEN Patient: _____Date of Accident: _____

I do hereby authorize Dr. Waterman to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

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

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

All "med pay" arising from the Incident is expressly and permanently assigned by Patient to Provider and will be immediately paid to Provider if received by Attorney or Patient. Attorney and Patient shall instruct the insurer to pay such entitlement directly to Provider. Med pay received will reduce the outstanding Bill by the amount of the "med pay" received by Provider.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

DATED _____ PATIENT'S SIGNATURE _____

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, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney agrees that any dispute arising under the terms of this agreement will be governed under the laws of the State of California and, further, that any such dispute will be venued in the superior court of the county in which care was performed. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

DATED _____ ATTORNEY SIGNATURE _____

-

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.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

CLAREMONT CHIROPRACTIC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective [date] given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

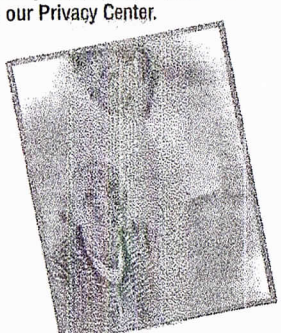
Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.



The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

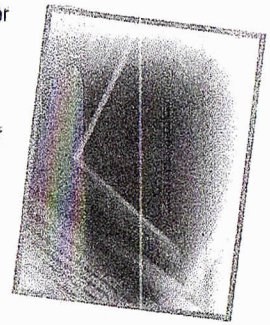
- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

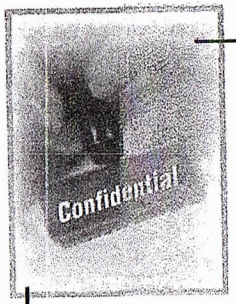
Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.





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 it carefully.

Effective Date: 6/7/2017

Privacy Officer:
E. MARK WATERMAN D.C.

CLAREMONT CHIROPRACTIC
2440 W. ARROW RTE. SUITE 5A
UPLAND, CA 91786
(909) 670-2225

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person repsonsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- Health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will breifly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.htm
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.