Date _____ **CONFIDENTIAL CASE HISTORY** Case# _____

Name _____
(First) (Middle) (Last) (Nickname- Name you go by)

Home Address _____ Birthdate _____/ _____/ _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ email _____

Sex: M F Marital Status: S M D W Social Security Number _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Name of Spouse (or Responsible Party if Patient is a dependent Child) _____

Spouse's (Responsible Party's) Birth date _____/ _____/ _____ Social Security Number _____

Spouse's Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Referred by _____ Past Chiropractic Care ☐ Yes ☐ No When? _____

Doctor's Name _____ Results _____

Chief Complaint 1. _____

2. _____

3. _____

Insurance Companies _____

Are your present injuries due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Personal Injury ☐ Other

Have you made a report of your accident? ☐ No ☐ Yes ☐ To employer ☐ Auto Carrier ☐ Other _____

Has the accident been reported? ☐ No ☐ Yes ☐ Workers Comp. ☐ Auto Carrier ☐ Other _____

Are you now or have you ever been disabled? (Service or Work)? ☐ No ☐ Yes When _____

Have you retained an attorney? ☐ No ☐ Yes Name & Address _____

PLEASE GIVE MOST CURRENT DATE

Spinal Exam _____

MRI Exam _____

X-ray Exam _____

Lab Exam _____

Last Physical _____

FEMALE ONLY

Papsmear _____

Breast exam _____

Implants _____

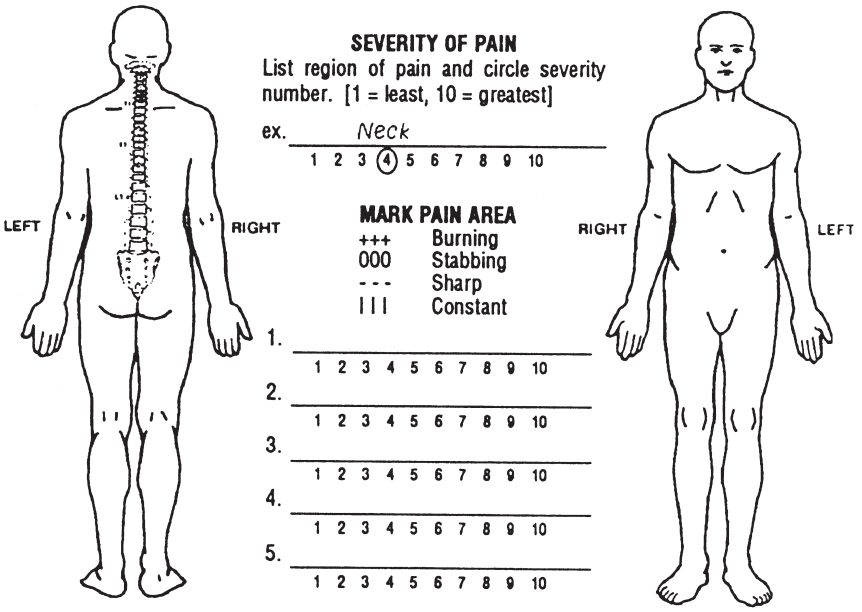
DOCTORS USE ONLY

_____

_____

_____

_____



SEVERITY OF PAIN
List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

MARK PAIN AREA
+++ Burning
000 Stabbing
- - - Sharp
| | | Constant

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10
4. _____ 1 2 3 4 5 6 7 8 9 10
5. _____ 1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

HABITS

☐ Smoking Packs/Day _____
☐ Drinking Alcohol _____
☐ Coffee Cups/Day _____

EXERCISE

☐ None
☐ Moderate
☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of ___	☐	☐	☐	☐	☐
Sister, No. of ___	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____541	Appendicitis	____285.9	Anemia	____429.9	Heart Disease	____716.9	Arthritis
____541	Pneumonia	____285.9	Measles	____429.9	Goiter	____716.9	Epilepsy
____541	Rheumatic Fever	____285.9	Mumps	____429.9	Influenza	____716.9	Mental Disorder
____541	Polio	____285.9	Chicken Pox	____429.9	Pleurisy	____716.9	Lumbago
____541	Tuberculosis	____285.9	Diabetes	____429.9	Alcoholism	____716.9	Eczema
____541	Whooping Cough	____285.9	Cancer	____429.9	Venereal Infection	____	AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if never. A complete history and understanding of you health will facilitate care.

GENERAL SYMPTOMS

_____784.0 Headache
_____780.6 Fever
_____780.9 Chills
_____780.8 Night Sweats
_____780.2 Fainting
_____780.4 Dizziness
_____780.3 Convulsions
_____780.52 Loss of Sleep
_____780.7 Fatigue
_____799.2 Nervousness
_____783 Loss of Weight
_____782 Numbness or pain in arms/legs/hands
_____995.3 Allergy (What)
_____786.09 Wheezing
_____729.2 Neuralgia

GASTRO-INTESTINAL

_____783 Poor Appetite
_____536.8 Poor Digestion
_____994.2 Excessive Hunger
_____787.3 Belching or Gas
_____787 Nausea
_____787 Vomiting
_____578 Vomiting Blood
_____536.8 Pain over Stomach
_____564 Constipation
_____558.9 Diarrhea
_____789 Colon Trouble
_____455.6 Hemorrhoids (Piles)
_____785.1 Liver Trouble
_____782.4 Jaundice
_____575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

_____368.9 Poor Vision
_____378.9 Crossed Eyes
_____379.91 Pain in Eyes
_____389.9 Deafness
_____388.70 Earache
_____388.30 Ear Noises
_____388.60 Ear Discharges
_____478.1 Nasal Obstruction
_____784.7 Nose Bleeds
_____462 Sore Throats
_____784.49 Hoarseness
_____477.9 Hay Fever
_____493.9 Asthma
_____460 Frequent Colds
_____240.9 Enlarged Thyroid
_____463 Tonsillitis
_____686.9 Sinus Trouble

RESPIRATORY

_____786.2 Chronic Cough
_____786.3 Spitting Blood
_____933.1 Spitting Phlegm
_____786.50 Chest Pain
_____786.09 Difficulty Breathing

GENITO-URINARY

_____788.3 Frequent Urination
_____788.1 Painful Urination
_____599.7 Blood in Urine
_____592 Kidney Infection
_____788.3 Bed Wetting
_____788.1 Inability to control Urine
_____601.9 Prostate Trouble

MUSCLE & JOINTS

_____ Weakness
_____ Twitching
_____847 Stiff Neck
_____722.10 Backache
_____719 Swollen Joints
_____781 Tremors
_____729.5 Foot Trouble
_____724.79 Painful Tail Bone
_____724.5 Pain Between Shoulders
_____563.3 Hernia
_____737.3 Spinal Curvature

CARDIO-VASCULAR

_____783 Rapid Heart
_____427.89 Slow Heart
_____401.9 High Blood Pressure
_____458.9 Low Blood Pressure
_____786.51 Pain over Heart
_____438 Previous Heart Trouble
_____719.07 Swelling Ankles
_____759.9 Poor Circulation
_____ Varicose Veins
_____436 Strokes

SKIN OR ALLERGIES

_____368.9 Skin Eruptions
_____698.9 Itching
_____278.8 Bruising Easily
_____701.1 Dryness
_____ Boils
_____782 Sensitive Skin
_____708.9 Hives or Allergy
_____692.9 Eczema
_____ Medicines
_____
_____

FOR WOMEN ONLY

_____786.2 Painful Periods
_____626.2 Excessive Flow
_____626.4 Irregular Cycle
_____627.2 Hot Flashes
_____625.3 Cramps or Backaches
_____634.9 Miscarriage
_____623.5 Vaginal Discharge
_____ Pregnant at this Time
_____ Last Pap
By Who _____
Other _____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other
	_____		_____		_____
	_____		_____		_____

List any accidents or falls and dates: ❒ Car _____ ❒ Recreational Vehicle _____ ❒ Sports _____
❒ School _____ ❒ Other _____

List any broken bones or dislocations (fractures): _____

Ever on crutches? ❒ No ❒ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ❒ Yes ❒ No

Were you ever knocked unconscious? ❒ Yes ❒ No

Have you ever had a lapse of memory? ❒ Yes ❒ No

Have you ever had x-rays taken? ❒ No ❒ Yes When? _____ By whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

Are you presently taking any medication - prescription or patent? ❒ No ❒ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

APC-CH-904.2

PCC PIZZA Clinic of CHIROPRACTIC

DR. BRADFORD J. PIZZA

3284 DOGWOOD DRIVE, HAPEVILLE, GA 30354 TEL: (404) 761-6200 FAX: (404)761-0825

ACTIVITIES OF LIFE

Patient's Name:_____#_____ Date:_____

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of life:

	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Carrying Groceries	☐	☐	☐	☐
Sit to Stand	☐	☐	☐	☐
Climbing Stairs	☐	☐_____ step(s)	☐_____ step(s)	☐
Pet Care	☐	☐	☐	☐
Driving	☐	☐_____ minute(s)/hour(s)	☐_____minute(s)/hour(s)	☐
Extended Computer Use	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Household Chores	☐	☐	☐	☐
Lifting Children	☐	☐	☐	☐
Reading/Concentration	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐ Upper/lower garments	☐ Upper/lower garments	☐
Shaving	☐	☐	☐	☐
Sexual Activities	☐	☐	☐	☐
Sleep	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Sitting	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Standing	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Yard Work	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Walking	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Sweeping/Vacuuming	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Dishes	☐	☐_____ minute(s)/hour(s)	☐_____ minute(s)/hour(s)	☐
Laundry	☐	☐	☐	☐
Garbage	☐	☐	☐	☐
Other	☐	☐	☐	☐

Patient's Signature:_____ Date:_____

PIZZA CLINIC OF CHIROPRACTIC

QUADRUPLE VISUAL ANALOGUE SCALE

Patient's Name:_____#_____ Date:_____

Please read carefully:

Instructions: Please circle the number the best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

CALCULATION: (Add 4 scores) _____ ÷ 4 _____ x 10 = OATS SCORE _____

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OFFICE POLICY AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

GENERAL INFORMATION

This authorization is requested by Pizza Clinic of Chiropractic for its own use/disclosure of protected health information. *(Minimum necessary standards apply.)* You have the right to inspect or copy the PHI to be used/disclosed. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Pizza Clinic of Chiropractic will not refuse to provide treatment. A copy of the signed authorization will be provided to you upon request.

SPECIFIC AUTHORIZATIONS

The patient identified above authorizes and grants permission for Pizza Clinic of Chiropractic to use and/or disclose protected health information (i.e., address, phone number, and/or clinical records) in the following ways:

- Birthday cards
- Holiday-related cards
- Newsletters
- Office marketing material
- Patient Referral Board
- New Patient Board
- Photo Board
- Thank You gifts/cards
- Appointment reminders

I also give Pizza Clinic of Chiropractic permission to treat me in an "open-room environment" whereas the door to the room will remain open. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will close the door to the room for these conversations.

By signing this form you are giving Pizza Clinic of Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above unless indicated otherwise and to treat you in an open-room environment.

This authorization shall expire on the following date: _____

_____ _____

Signature of patient (parent/guardian if patient is a minor) Date

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization in whole or part, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

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CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

AUTHORIZATION AND ASSIGNMENT

In Consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company(the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and /or recovery in this state, _____.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed,_____, are paid in full.

_____ _____

Signature Date

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer chiropractic care as he/she deems necessary to my _____ (indicate relationship of child).

_____ _____

Name (child's Name)/ (Nombre del Menor) City & State where this was signed

_____ _____ _____ _____

Date/ (Fecha) Signature/ (Firma) Date Witness Signature

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body and opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through reduction of the VAA or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic Procedures. Sometimes the response is phenomenal.

In most cases there is more gradual, but quite satisfactory response. Occasionally, the results are less expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The Patient should discuss any questions or problems with the doctor before singing this statement of policy.

I have read the foregoing and understand it.

_____ _____

Patient Signature Date Witness Date

PIZZA Clinic of CHIROPRACTIC

DR. BRADFORD J. PIZZA

3284 DOGWOOD DRIVE, HAPEVILLE, GA 30354 TEL: (404) 761-6200 FAX: (404)761-0825

To: _____

Fax: _____

From: _____

RECORDS RELEASE

RE: Patient's Name: _____

Date of Birth: _____

To _____, I hereby authorize you to release to **Pizza Clinic of Chiropractic** any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

_____ _____

Signature Date

_____ _____

Witness Signature Date

____ Please fax all medical records to: (404) 761-0825.

____ Please mail all medical records to: 3284 Dogwood Drive, Hapeville, GA 30354.

____ Please mail a copy of patients X-RAY / MRI / CT to: 3284 Dogwood Drive, Hapeville, GA 30354

____ Patient is currently in our office.

PIZZA Clinic of CHIROPRACTIC

DR. BRADFORD J. PIZZA

3284 DOGWOOD DRIVE, HAPEVILLE, GA 30354 TEL: (404) 761-6200 FAX: (404)761-0825

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

I have read or been provided with a *Notice of Patient Privacy Practices* that provides a description of healthcare information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or Disclosed to carry out treatment, payment, or healthcare operations.

_____ _____

Patient Signature Date

PIZZA Clinic of CHIROPRACTIC

DR. BRADFORD J. PIZZA

3284 DOGWOOD DRIVE, HAPEVILLE, GA 30354 TEL: (404) 761-6200 FAX: (404)761-0825

NOTICE OF PATIENT PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

I. Uses and Disclosures

Pizza Clinic of Chiropractic may use or disclose your protected health information without your written consent, written authorization, or oral agreement for the following purposes:

Treatment: We may use your health information within our office to provide healthcare services to you. We may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment: We may disclose your health information to a third party, such as an insurance carrier (i.e., HMO, PPO), an attorney, a collection agency, or your employer, in order to obtain payment for services provided to you.

Healthcare Operations: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities such as scheduling and appointment reminders.

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

- If we provide services to you while you are an inmate.
- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition, or death.
- If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury, or disability.
- If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
- If we are required to disclose your health information to the Food and Drug Administration.
- If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
- If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.

- If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
- If we are required to disclose your health information in response to a court order or a subpoena.
- If we are required to disclose your health information to a law enforcement official.
- If we are required to disclose your health information to a coroner, medical examiner, or funeral director.
- For research purposes.
- If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEATH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information; however, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12-month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures made to you.
- Disclosures made in our facility directory.
- Disclosures made to individuals involved with your care.
- Disclosures made for national security or intelligence purposes.
- Disclosures made to correctional institutions or law enforcement officials.
- Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect; however, we reserve the right to change the

terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact our Privacy Official:

Astry L. Avila
3284 Dogwood Drive
Hapeville, GA 30354
(404) 761-6200

EFFECTIVE DATE OF NOTICE: 03/28/2003