WELCOME!

Battle Born Chiropractic is a place where people come and feel like family. It is about LIFE, people, health and community. The kid friendly environment, homelike atmosphere, and lively music are unique and unlike the typical doctor's office. Battle Born Chiropractic is a safe oasis which facilitates your best possible chiropractic adjustment, and the well-being of your body, mind and spirit.

At Battle Born Chiropractic you will be cared for as a unique individual. The following pages are for you to provide vital information and a brief outline of your life's story. Much of this information will be discussed in our first appointment. Dr. Rachel believes in addressing the whole person, not just one specific problem. We are a sum total of all of our life's experiences up to this present moment. The more information you can provide, the better she can serve you. Dr. Rachel is honored to contribute to your and your family's enhanced quality of life on your path to health, happiness and wellness.

Please make sure to fill out this Intake paperwork and email it to drrachel@battlebornchiropractic.com or fax it to 775-470-5402 a minimum of 48 hours before your first appointment. This gives Dr. Rachel the time to review your paperwork before your consult and exam. If this is not done, your appointment will be cancelled and need to be rescheduled.

Thank you! Can't wait to see you!

Adult Intake Form

Patient Name: _____ Date:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Additional phone: _____

Email: _____

Birth Date: _____ Age: _____ Gender: _____

Social Security Number: _____

Spouse/Significant Other's Name: _____ Phone: _____
Marital Status (Please circle): Single Married Partnered Widowed Divorced Separated

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____

How did you hear about us? ☐ Facebook ☐ Instagram ☐ Internet Search
☐ Family/Friend (WHO MAY WE THANK FOR REFFERRING YOU? _____)
☐ Midwife _____ ☐ Doula _____
☐ Lactation Consultant _____ ☐ Other _____

Reason for seeking services at Battle Born Chiropractic:

_____

Is there anything about your spine or nerve system that I should know?

_____

Are you experiencing any symptoms? If so, explain:

_____

_____

What is your level of commitment to your health, and your life?
High: _____ Medium: _____ Low: _____

Do you have any previous experience with Chiropractic? If so, who was your last Chiropractor?

_____

Lifestyle History

History of Physical Stress (ex. Sports, work, surgeries, accidents, falls, trauma):

_____

_____

History of Chemical Stress (ex. Alcohol, drugs, tobacco, environmental toxins):

_____

_____

History of Emotional Stress (ex. Work, family, life):

_____

_____

What did you have for breakfast, lunch and dinner yesterday? (Be honest)

_____

Please Circle Dietary Intake: Fruits Vegetables Meats Grains Dairy Nuts/Seeds Sugar Eggs Seafood

How much water do you drink daily? _____

What exercise to you do and how often? _____

_____

What do you do for work? _____

What is your level of satisfaction with your career? (circle one) GREAT OK DISSATISFIED

When was your last vacation? _____

What do you do for fun/play? _____

What do you do for relaxation? _____

What do you do for self-care? _____

What are your Top 3 Health Goals? _____

_____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #: _____ Date: _____

Instructions: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. **Please answer every section** and mark in each section only the **ONE** box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance. I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5-SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

Patient Name: _____ **Date:** _____

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better. My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

_____	_____	_____
Total Score	% Disability	Scored by: Dr. Rachel Whitman D. C

Neck Disability Index

Patient Name: _____ **File #:** _____ **Date:** _____
Instructions: This questionnaire has been designed to give your health practitioner information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section** and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time.

Patient Name: _____ **Date:** _____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all. I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

_____	_____	_____
Total Score	% Disability	Scored by: Dr. Rachel Whitman D. C

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 typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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: _____

Terms of Acceptance

When a person seeks chiropractic care and I accept a person for such care, it is essential for both to be working for the same objective. The following definitions help to clarify some of the fundamentals of chiropractic.

HEALTH: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." – World Health Organization

VERTEBRAL SUBLUXATION: a misalignment of one or more vertebrae in the spinal column that alters function, which inhibits the body's ability to fully express its inherent potential.

ADJUSTMENT: The specific application of forces to facilitate the body's correction of vertebral subluxation. This is done by the use of a chiropractor's hands on your back and/or a small instrument.

Battle Born Chiropractic offers to provide chiropractic care to correct the vertebral subluxation. Dr. Rachel's objective is to eliminate major interference of the nerve system for the expression of the body's natural ability to heal and grow. Other procedures may be used to help your body maintain the benefits of the adjustments. If during the course of a chiropractic neuro-spinal analysis we encounter non-chiropractic or unusual findings, we will advise you to seek the services of another healthcare specialist.

At Battle Born Chiropractic, health is a dedicated and active process that is achieved through our partnership with the objective of optimizing your health and life.

I, _____ have read and fully understand the above statements.

All questions regarding Dr. Rachel's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

(Please sign after Dr. Rachel has gone over your results and accepted you for care)

_____ _____

Patient Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Medicare Information

In consideration of undertaking your care, there is some information regarding Medicare we want all Battle Born Chiropractic patients to aware of:

- Medicare is likely to cover at least some of your chiropractic care.
- Medicare handles chiropractic care differently form medical treatment.
- Medicare **ONLY** covers the cost of chiropractic adjustments designed to help correct vertebral subluxation.
- Medicare **REQUIRES** an examination to identify the presence of vertebral subluxation
- **BUT Medicare DOES NOT pay for the cost of the exam or any needed x-rays**. (Dr. Rachel will refer you to your Primary Doctor so he/she can request any pertinent x-rays, so Medicare will likely cover them).
- For Medicare to pay for your adjustments, they must be **"medically necessary"**. That means:
    1. Your adjustments must relate directly to your specific health complaint,
    2. Your adjustments must hold the promise of making functional improvements, and
    3. You must follow your chiropractor's specific plan for Active Treatment
- **Functional Improvement:** Instead of judging your progress simply by how you feel, Medicare wants to see improved function. That means a restored ability to turn, bend, walk, sleep and generally perform your daily activities. **Once improvement stops, Medicare coverage stops**. That's because they consider further care to be maintenance and expect you to self-pay.
- **Maintenance Care:** Medicare does not pay for chiropractic care to maintain your progress or to help prevent disease, promote health, and prolong and enhance the quality of life. While most patients see the wisdom of some type of wellness care, Medicare does not pay for it. Recognizing the value of protecting their improvement, many opt to self-pay.
- **Maximum Improvement:** The number of adjustments covered by Medicare varies. It's based on the severity of your condition(s). Sometimes, more visits will be needed than what Medicare will pay for. If continued care seems promising to you (but not Medicare), you may pay for the care yourself.
- **Non Participating Medicare Provide**r: Battle Born Chiropractic is a Non Participating Medicare Provider. That means, on each visit we will collect our fee from you (set by Medicare) for the chiropractic adjustment. Then we will bill Medicare for you. They will reimburse you 80% up to the dollar limits they set. If you have supplemental insurance, it may assume some or all of your 20% co-payment and excluded services.

Regardless of Medicare coverage, we promise to make the recommendations that can best help you. We'll do everything we can to make your chiropractic care affordable. We look forward to showing you ways to get well and stay well. Naturally. Without drugs or surgery.

I, _____, have read and understand all the above information regarding Medicare and my chiropractic benefits.

Patient Name: _____

Patient Signature: _____ **Date:** _____

A. Notifier: Battle Born Chiropractic 3740 Lakeside Drive #202 Reno, Nv 89509

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Exams (Initial and Re-evaluations)	Not a Covered Expense	$40-$100
Preventative/Wellness Care	Not Considered Medically Necessary	$50/visit
Consults	Not a Covered Expense	$25 per 15 minutes

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Battle Born Chiropractic, LLC

Dr. Rachel Whitman

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 1, 2019, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. 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.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

PRIVACY OFFICER, Battle Born Chiropractic

3740 Lakeside Drive STE #202

Reno, Nv 89509

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received, reviewed,
(Patient Name)
understand and agree to the Notice of Privacy Practices of Battle Born Chiropractic, LLC and Dr. Rachel Whitman, D.C., which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Print Name: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

Battle Born Chiropractic has made a good-faith effort to obtain an acknowledgement of

_____ 's receipt of our Notice of Privacy Practices. In spite of
(Patient Name)

these efforts, Battle Born Chiropractic has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

_____ Patient Unavailable

_____ Patient Physically Unable

_____ Patient Unwilling

In effort to obtain the patient's acknowledgement, Battle Born Chiropractic has attempted to provide patient with a Notice of Privacy in the following manner (check all that apply):

_____ Personally _____ Mail _____ Phone Follow Up ____ Other: _____

Signature: _____ **Date:** _____

Print Name of Physician: _____

Please direct any questions to:

Dr. Rachel Whitman, D.C.
Office Phone: 775-826-2676
3740 Lakeside Drive STE #202 Reno, Nv 89509

Authorization of Release

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

- You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
- I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient Signature:_____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Seeking Care at Battle Born Chiropractic

I, _____, voluntarily choose to seek care at Battle Born
(Print Name)
Chiropractic. Dr. Rachel did not seek or solicit me to come to her office for Chiropractic Care.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Financial Policy

Collection of Patient Balance:

- Dr. Rachel Whitman is an Out of Network Provider with all insurance companies and is a Non-Participating Provider with Medicare.
- As a Non-Participating Provider with Medicare, Battle Born Chiropractic will collect payment directly from Medicare Patients at the time of service. Medicare is the only provider Battle Born Chiropractic will submit claims to on behalf of the patient, and the patient may be reimbursed for the portion of the charges for which Medicare is responsible.
- Payment is expected in full at the time of service.
- Battle Born Chiropractic can provide you everything you need to be reimbursed by your insurance based on your benefits.
- If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit.
- All balances remaining unpaid after 30 days may be turned over to a collection agency.

Returned Checks:

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments:

- If unable to keep an appointment, as a courtesy to our staff and other patients, please give 24-hour notice. Battle Born Chiropractic will offer a courtesy of **two (2) missed appointments** without adequate notice. **After two (2) missed/canceled visits without 24-hour notice, the patient will be charged $50.00 for each visit that is missed.** The patient will be responsible for payment.

Financial Policy Question:

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Dr. Rachel Whitman.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Release Form for Media

I, _____, do hereby grant or deny permission to Battle Born Chiropractic to use the image of myself/my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or videos taken of myself/my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on Battle Born Chiropractic website, Facebook and/or Instagram.

☐ Deny permission to use mine/my child's image at all.

☐ Grant permission to use mine/my child's image in the following ways (mark all the apply):

- ☐ Limited usage: I want mine/my child's image used within the Battle Born Chiropractic Office setting only (not in the larger community)
- ☐ Limited usage: I want mine/my child's image used for educational materials only (not marketing). This could be either within Battle Born Chiropractic office or in the larger community. One example of this could be videos in parent education classes.
- ☐ Limited usage: I want mine/my child's image used on printed materials only (no digital or video use).
- ☐ Unrestricted usage: I give unrestricted permission for mine/my child's image to be used in print, video, and digital media. I agree that these images may be used by Battle Born Chiropractic for a variety of purposes and that these images may be used without further notifying me. I do understand that mine/my child's last name will not be used in conjunction with any video or digital images.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Please make a copy of this form for your own records and mail or fax the original to:

Dr. Rachel Whitman
Battle Born Chiropractic
3740 Lakeside Drive Ste #202
Reno, Nv 89509
Fax: 775-470-5402

If you have any questions, contact Dr. Rachel Whitman at 775-826-BORN