

CHIROPRACTIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____

Relationship to Patient _____

3

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____

Attorney Name (if applicable) _____

5

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

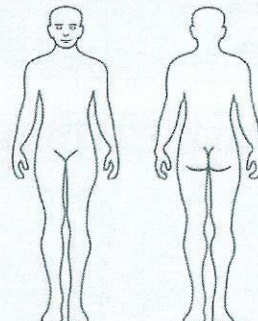
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- ☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

- ☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

- ☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

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

7

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

Jones Chiropractic Clinic

Jeffery P. Jones, D.C.

121 Executive Dr.

Madison, MS 39110

Office (601) 856-8850

RADIOLOGY REQUISITION

Date: _____

Patient File #: _____

Patient Name: _____
Last First MI

Date of Birth: _____ Sex ☐ M ☐ F

To the best of my knowledge I am **NOT PREGNANT** and I give my permission to be X-rayed
for diagnosis interpretation.

Patient Signature: * _____

Patient Authorization for X-rays: *

MUST SIGN HERE

(Patient signature OR Parent or guardian signature for minors)

Date of last X-ray(s): _____ Area radiographed: _____

X-ray Performed by: _____

FOR OFFICE USE ONLY:

	<u>VIEW TAKEN</u>	<u>CM</u>	<u>Ma</u>	<u>SEC</u>	<u>KVP</u>	<u>FFD</u>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____	_____

Jones Chiropractic Clinic PAYMENT POLICY & AGREEMENT

CHIROPRACTIC SERVICES PROVIDED IN THIS OFFICE ARE PAYABLE THE DAY SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SEEING THE DOCTOR.

1. PATIENTS ARE PERSONALLY RESPONSIBLE FOR ALL CHARGES.
2. **ASSIGNMENT WILL BE ACCEPTED ON PRIMARY AND SECONDARY INSURANCE. PRIMARY CLAIMS WILL BE BILLED ELECTRONICALLY. WE DO NOT ACCEPT ASSIGNMENT ON THIRD PARTY LIABILITY CLAIMS AS THEY ARE NON-ASSIGNABLE.**
3. THERE WILL BE A \$50 MINIMUM CHARGE FOR MEDICAL RECORDS REQUESTED BY LIABILITY CARRIERS, ATTORNEYS, OR INSURANCE APPLICATION REQUESTS. THERE WILL BE A \$6.00 CHARGE FOR INSURANCE CLAIMS THAT HAVE TO BE RESUBMITTED MORE THAN TWICE.
4. *PAYMENT PLANS ARE AVAILABLE UPON APPROVAL OF CREDIT EXTENTION BY OFFICE MANAGER. I AUTHORIZE A CREDIT CHECK IF CREDIT IS EXTENDED. (Initial only if credit arrangements are desired)*
5. OCCASIONALLY, DUE TO CHANGES IN INSURANCE COVERAGE, A PATIENT MAY AQUIRE A NEGATIVE BALANCE. REFUNDS WILL ONLY BE MADE WHEN ALL CLAIMS HAVE BEEN PROCESSED. NEGATIVE BALANCES OF \$11-\$20 WILL BE HELD FOR FUTURE SERVICES UNLESS THE PATIENT HAS NOT BEEN SEEN FOR 12-18 MONTHS AT WHICH TIME A REFUND WILL BE ISSUED. NEGATIVE BALANCES OF \$10 OR LESS WILL REMAIN AS A CREDIT BALANCE.

AUTHORIZATION

6. I AUTHORIZE RELEASE OF ALL INFORMANTION REGARDING MY CONDITION TO ANY INSURANCE CO. ATTORNEY, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIMS FOR REIMBURSEMENT AND RELEASE YOU OF ANY CONSEQUENCES THEREOF. I ALSO ASSIGN AND TRANSFER TO YOU THE CAUSE OF ACTION THAT EXISTS IN MY FAVOR SO THAT YOU MAY ACT IN MY BEHALF TO RESOLVE ANY INSURANCE CLAIM AND I DIRECT ANY INSURANCE PLAN OR BENEFIT OBLIGATED TO REIMBURSE ME FOR COVERED SERVICES TO MAKE PAYMENT DIRECTLY TO THE PROVIDER(S) AT JONES CHIROPRACTIC CLINIC.
7. **A LATE FEE OF 1.5% WILL BE ADDED TO ALL ACCOUNTS WHICH CO-PAY, DEDUCTIBLE OR PATIENT BALANCE (AFTER INSURANCE PAYMENT) HAS NOT BEEN PAID WITHIN 30 DAYS OF THE DATE OF SERVICE. LATE CHARGES ARE NOT APPLIED TO BALANCES PAYABLE BY THE INSURANCE CARRIER. VERIFICATION OF BENEFITS AND INFORMATION INSURANCE CARRIER PROVIDES IS NOT A GUARANTEE OF PAYMENT AND THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED.**
8. ***IF AN ACCOUNT IS OVER 90 DAYS PAST DUE WITH NO PAYMENT ACTIVITY (AFTER INS. HAS PAID OR DENIED ON ASSIGNED CLAIMS), THE ACCOUNT WILL BE PLACED FOR COLLECTION AND A COLLECTION FEE BASED ON THE BAL. DUE & LEGAL FEES WILL BE ADDED TO THE ACCOUNT.***

I UNDERSTAND THAT IF IT IS DETERMINED EITHER: a. The insurance listed is not obligated to pay for the services, or b. If the insurance company involved refuses to acknowledge an assignment to the clinic/doctor(s), or c. Charges are not paid in the amount verified at initial visit, I will be responsible for payment of those services in full. (Unless other financial arrangements are made with the office manager.)

Patient Signature/ or Guardian

Date

Witness

Date

WE WILL MAKE EVERY EFFORT TO VERIFY YOUR INSURANCE COVERAGE AND COLLECT CO-PAY AND DEDUCTIBLE AS DISCLOSED; HOWEVER, NO INSURANCE CARRIER GUARANTEES PAYMENT OR CORRECTNESS OF INFORMATION UPON VERIFICATION. YOU ARE RESPONSIBLE FOR KNOWING THE TERMS OF YOUR INSURANCE POLICY.

Jones Chiropractic Clinic
121 Executive Drive
Madison, MS 39110
601-856-8850

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Patient

Signature

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) _____

Staff signature

Date

Jones Chiropractic Clinic

PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THAT INFORMATION.**

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USE AND DISCLOSURE OF INFORMATION

- 1) The Practice may use and/or disclose your PHI for the purposes of:
 - a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.
 - b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
 - c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.
- 2) The Practice may also use and/or disclose your PHI in the following instances:
 - a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
 - b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
 - c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
 - d) Emergency Situations –
 - i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your acknowledgement of our Privacy Notice as soon as possible; or
 - ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
 - e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your acknowledgement of our Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.
 - f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.
 - g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
 - h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
 - i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
 - j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
 - k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

- l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
- n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- o) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.
- p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
- q) National Security and Intelligence Activities - The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
- r) Military and Veterans - If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

3) APPOINTMENT REMINDER, CHIROPRACTIC BULLETIN, BIRTHDAY, & REFERRAL THANK YOU

The Practice may, from time to time, 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. The following appointment reminders are used by the Practice: a) a postcard or bulletin mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone and c) all electronic communications via reminder servicing vendor. The Practice recognizes patient birthdays and sends referral thank you cards (listing the patient referred) by mailing a postcard to you at the address provided by you.

4) DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

5) FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
- b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

6) AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

7) YOUR RIGHTS

You have the right to:

- a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

- d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.
- e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
- h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
- i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Karen Johnson, 737 A-1 Highway 51, Madison, MS 39110 or 601)856-8850.

8) **PRACTICE'S REQUIREMENTS**

The Practice:

- a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- b) Is required to abide by the terms of this Privacy Notice.
- c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- d) Will distribute any revised Privacy Notice to you prior to implementation, if specifically requested by you. Otherwise, it will be distributed at your next visit, and will be available upon request. We will also distribute it by
- e) E-mail if you give us your E-mail address.
- f) Will not retaliate against you for filing a complaint.

9) **EFFECTIVE DATE:**

This Notice is in effect as of 4/14/03.