Chiropractic Sports and Rehabilitation Center
856-874-0080

CONFIDENTIAL PATIENT CASE HISTORY

General Information

Name Dr./Ms/Mrs/Mr _____ Mid Initial _____
Last Name _____
Called Name _____
Address _____
City, State, Zip _____
Home Phone _____ Cell Number _____
Email Address _____

□Married □Single □Divorced □Widowed Number of Children _____

Date of Birth _____/_____/_____ Sex □Male □Female
How would you like appointment reminders □cell □home □email □text □none
Referred by _____

Employer Information

Employer _____ Occupation _____
Address _____
City, State, Zip _____
Work Phone Number _____
Work Status □Full Time □Part Time □ Full Time Student □Part Time Student
□Unemployed □On Disability for: _____

Insured Information

Patient is the □Same/Self □ Husband □ Wife □ Child □Other of Insured
First Name _____ Middle Initial _____ Last Name _____
Address _____
City, State, Zip _____
Phone Number _____ **Date of Birth** _____/_____/_____

Social Security Number _____-_____-_____ Sex □Male □Female

Insurance Information

Ins. Company Name _____
Plan Name _____
Policy Number/Insurance ID _____
Group Number _____
Ins Phone Number _____

Is this your **primary medical insurance** □Yes □No
Do you have **secondary** medical insurance □Yes □ No

Patient's/Guardian's Signature _____ **Date** _____

Patient Intake Form

Name: _____ Date: _____

CURRENT INJURY

When did the current condition / injury start: _____

Are your present problems due to an injury? ❑Yes ❑No

Is your condition/injury related to? ❑At Home ❑Gym ❑Work ❑Auto Accident ❑Personal Injury ❑Other:

Briefly describe how your condition came about:_____

_____

_____

List any tests, studies or medications and treatment received for this **current condition**: ❑None

❑X-Rays _____ ❑MRI/CT_____ ❑PT_____ ❑Pain Management _____

❑Orthopedic _____ ❑ Neurology _____ ❑ Chiropractic _____ ❑PCP_____

❑Medications:_____

Do you have any current work restrictions due to this condition? ❑No ❑Yes:_____

Are you on Disability for this or any other condition? ❑No ❑Yes:_____

Is your current condition ❑constant ❑come and goes

Is your current condition ❑staying the same ❑is getting currently worse

Is the current condition interfering with ❑work ❑sleep ❑daily routine ❑other _____ ❑none

What activities aggravate your condition ❑sitting ❑standing ❑walking ❑bending ❑twisting ❑exercising

What therapies helps your current condition ❑rest ❑ice ❑heat ❑medications ❑OTC_____

Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? _____ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: _____ Date Released: _____ Length of Stay: _____

PAST MEDICAL HISTORY

Do you suffer from any condition other than that for which you are now consulting us? ❑No ❑Yes_____

List any past conditions you may have had:

_____

_____

_____

_____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker ❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): ____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

Patient's/Guardian's Signature: _____ **Date:** _____

EXERCISE

❑ None ❑1/week ❑2/week ❑ 3/week ❑4/week ❑ 5 or more /week

FAMILY HISTORY ❑ Adopted/Unknown

	Diabetes	Cancer	Arthritis	Stroke	Thyroid Disease	Heart Disease	None
Mother	❑	❑	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ _____

❑ Oral ❑ Intravenous ❑ Other: _____

Frequency: _____

Began Use: _____

Medication: _____

❑ Oral ❑ Intravenous ❑ Other: _____

Frequency: _____

Began Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones? _____

Do you have allergies? ❑Yes ❑No If yes, which ones?: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, enter type and approximate date of surgery.)

Have you ever had any of the following studies in the past ❑X-rays ❑MRI ❑CT Scan ❑Ultrasound ❑None

❑Other_____ When? _____

For what ailments were these studies taken? _____

Have you had prior injuries related? ❑At Home Injury ❑Gym Related ❑Job Related ❑Auto Accident

❑Slip and Fall ❑Other_____ ❑None

Have you ever had any prior Chiropractic or Physical Therapy? ❑Yes Chiropractic ❑Yes Physical Therapy

❑ None

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendix	❑ Goiter	❑Epilepsy	❑Mumps	❑ Influenza
❑Mental Disorder	❑Polio	❑Chicken Pox	❑Pleurisy	❑ Spleen
❑ Tuberculosis	❑ Drug Use	❑Alcoholism	❑ Eczema	❑Cancer
❑ HIV Positive	❑ Measles	❑ Venereal Disease	❑Rheumatic Fever	
❑Whooping Cough	❑**None**			

I hereby authorize the doctor to examine and treat my condition as he/she 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 imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____ _____

Current Complaints

Choose the severity level and frequency associated with each symptom

Headaches

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

---

At its **Worst** Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency at its **Worst**: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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Neck /Shoulder

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

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Frequency at its **Worst**: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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Arm/Hand

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

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Frequency at its **Worst**: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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Upper/Mid Back

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

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At its **Worst** Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency at its **Worst**: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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Patient's/Guardian's Signature: _____ **Date:** _____

Lower Back/Buttock/Hip

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

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At its **Worst** Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency at its **Worst:** ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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Leg/Ankle/Foot

Current Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Current Frequency: ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑ Constant (76-100%) ❑None

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At its **Worst** Intensity __0 ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency at its **Worst:** ❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (76-100%) ❑None

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I hereby authorize the doctor to examine and treat my condition as he/she 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 imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Clinic 1
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

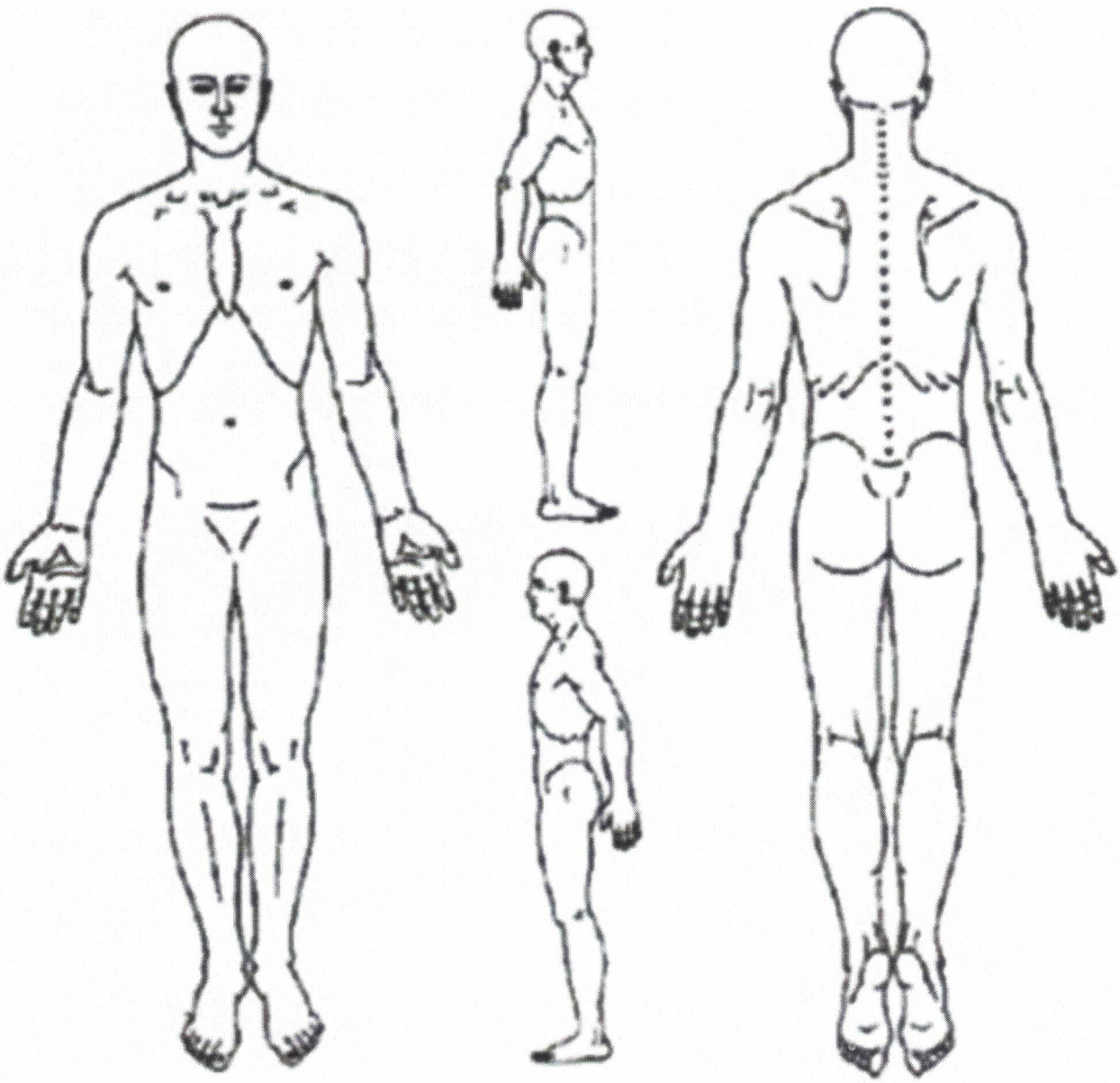
Name: _____

Date: _____

Mark the areas on this body where you feel the described pain and sensory issues. Make sure to add any pain that radiates down into the shoulder, arms, hand and/or legs/feet.
Use the appropriate symbols.

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	00000000000	xxxxxxx	*******	///////
----------	00000000000	xxxxxxx	*******	///////

PAIN CHART



I hereby authorize:

Paul G. Rykaczewski, D.C., C.C.S.P.
Chiropractic Sports and Rehabilitation Center
102 Sheppard Road
Voorhees, New Jersey 08043

and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship to child),

_____

(Full Name of Child)

Date: _____

Print: _____
(Parent or Guardian)

Signed: _____
(Parent or Guardian)

Effective Date of this notice: April 14, 2003

Chiropractic Sports and Rehabilitation Center
Of Voorhees
Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how Personal Health Information about you as a patient of this practice may be used disclosed, and how you can get access to your individually identifiable health information.

OUR COMMITMENT TO YOUR PRIVACY:

We are dedicated to maintain the privacy of your individual **identifiable health information (IIHI).** In conducting our business we will create records regarding you and the treatment and services we provide to you. By federal and state law, we must provide you with the following information: how we may use and disclose your IIHI; your privacy rights related to your IIHI; and our obligations concerning our use and disclosure of your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that our practice has created in the past or may create in the future. This notice will be posted in a visible location at all times, and you may request (in writing) a copy of our most current notice at any time.

If you have questions concerning this notice, please contact:

Paul G. Rykaczewski, D.C
102 Sheppard Road
Voorhees, NJ 08043

WE MAY USE & DISCLOSE YOUR IIHI IN THE FOLLOWING WAYS:

1. **TREATMENT.** Our practice may use your IIHI to treat you. For example, people working for this practice, including but not limited to Dr. Rykaczewski, any associates, and our staff may use and disclose your IIHI to others when referring you to other physicians (including but not limited to primary care physicians, orthopedic physicians, neurological physicians, radiologists, and pain management physicians). Additionally we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. **PAYMENT.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, or pre-certify your treatment, and we may provide your insurer with the details regarding your treatment to determine if your insurer will pay for your treatment. We may also use and disclose your IIHI in order to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **HEALTH CARE OPERATIONS.** We may use and disclose your IIHI to operate our business. As examples of ways in which we may use this information for our operations, we may use your IIHI to evaluate the quality of care you received from our office, or to conduct cost-management and business planning activities for our practice. We may use your IIHI to contact you in writing, by phone or by leaving a message on your voice mail or with an adult member of the household who answers the phone reminding you of an appointment. We may use your IIHI in order to inform you of potential treatment options or alternatives, or to inform you of health-related benefits or services that may be of interest to you. We may release your IIHI to a friend or a family member that is involved in your care and treatment. For example, a parent/ guardian may ask a babysitter to take a child to the doctor to receive treatment for an illness. In the example, the babysitter may have access to this child's medical information.

4. **DISCLOSURES REQUIRED BY LAW.** We will use and disclose your IIHI when required to do so by federal state and local law.

5. **SPECIAL CIRCUMSTANCES.**

   A. **Public Health Risks.** We may use and disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of: maintaining vital records, such as births and deaths; reporting child abuse or neglect; preventing or controlling disease or injury; notifying a persons regarding potential exposure to or a potential risk for spreading or contacting a communicable disease or condition;

reporting reactions to drugs or problems with products or device has been recalled; notifying an individual that a product or device has been recalled; notifying the appropriate government agencies/authorities regarding the potential abuse or neglect of an adult patient, including domestic violence; notifying your employer under limited circumstances related to workplace injury or illness.

B. **Health Oversight Activities.** We may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative and criminal procedures or actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and healthcare systems in general.

C. **Lawsuits and Similar Proceedings.** Our practice may use and disclose you IIHI in response to a court order, including a discovery request, subpoena, or other law process.

D. **Law Enforcement.** We may release IIHI if asked to by law enforcement official regarding a crime; concerning a death believed to have resulted in a criminal conduct; regarding criminal conduct in our office, in response to a warrant or summons, court order, subpoena or similar legal process; to identify/locate a suspect, material witness, fugitive or missing person; in an emergency to report a crime, to a medical examiner or coroner to identify a deceased individual or identify a cause of death, or to funeral directors to perform their jobs; to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials.

E. **Military & National Security.** We may release you IIHI if you are a member of the US or foreign military service if required by the appropriate authorities, or to federal officials for intelligence and national security activities authorized by law, or to protect the president, other officials or foreign heads of state, or to conduct investigations.

6. YOUR RIGHTS REGARDING YOU IIHI

A. **Confidential Communications.** You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. In order to request confidential information, you must make a **written** request to Paul G. Rykaczewski, D.C. at 102 Sheppard Road, Voorhees, NJ 08043. The request must specify the requested method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests.

B. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members. We are not required to agree with your request. In order to request a restriction in our use and disclosure of your IIHI, you must make your request **in writing** to Paul G. Rykaczewski, D.C. at 102 Sheppard Road, Voorhees, NJ 08043. Your request must describe in clear and concise fashion: the information you wish restricted; whether you are requesting to limit our use, disclosure, or both and to whom you want the limits to apply.

C. **Inspection and Copies.** You have the right to inspect and to obtain a copy of your IIHI that may be used to make decisions about you, including patient records and billing records, but not including psychotherapy notes. You must request **in writing** to Paul G. Rykaczewski, D.C. at 102 Sheppard Road, Voorhees, NJ 08043 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect/copy in certain limited circumstances; however, you may request a review of our denial in writing. Another licensed health care professional chosen by us will conduct the reviews.

D. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept for our practice. To request an amendment, your request must be made in writing to Paul G. Rykaczewski, D.C. at 102 Sheppard Road, Voorhees, NJ 08043. You must provide us with a reason that supports your request for the amendment. **Your request will be denied if you fail to submit the request and the reason supporting the request in writing. We can only amend IIHI that is created by this office—we cannot amend a specialist report, lab result, ect...**

F. **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain non-routine disclosures our practice has made of IIHI for non-treatment or operation purposes. Use of your IIHI as a part of the routine care in our practice is not required to be documented. For example, the doctors may share information with the office staff, or billing department

using your information to file your claim. In order to obtain an accounting of disclosures, you must make your request in writing to Paul G. Rykaczewski, D.C. at 10 2 Sheppard Road, Voorhees, NJ 08043. All requests for accounting disclosures must state a time period, which may not be longer that 6 years, from the date of the disclosure and may **not** include dates before April 14, 2003. The first request you make within a 12 month period of the disclosure is free of charge, but we may charge you for additional list within the same 12 month period. We will notify you of any costs that you may incur, and you may withdraw your request in writing before any costs are incurred.

G. **Right to a Paper Copy of this notice.** You are entitled to a paper copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the office manager at 102 Sheppard Road, Voorhees, NJ 08043.

H. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Human Services. To file a complaint with our practice, contact Paul G. Rykaczewski, D.C. at 102 Sheppard Road, Voorhees, NJ 08043. All complaints must be received in writing. You will not be penalized for filing a complaint.

I. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by law. Any authorization you provide us regarding the use and disclosure of your IIHI may be revoked at any time, in writing. After your revoke of authorization, we will no longer use or disclose your IIHI for reasons described in the authorization. Please note: we are required to retain records of your care.

J. **Complaints to Government.** You may make complaints to the Secretary of the Department of Health & Human Services if you believe your rights have been violated. You may contact DHHS at:

US Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
1(800) 696-6775

Paul G. Rykaczewski, D. C., C.C.S.P.
102 Sheppard Road
Voorhees, NJ 08043

Chiropractic Sports and Rehabilitation Center
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An Emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify)

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