TOTAL LIFE CARE CHARLESTON

Chiropractic Registration and History
(All Information is Confidential)

Date: _____

PATIENT INFORMATION

Please present driver's license and insurance cards(s) to the front desk, so we can copy them.

Patient Name: _____ Social Security # _____-_____-_____
Address: _____ Date of Birth: _____
City: _____ST _____ Zip _____ Age: _____

Height _____ Weight _____ Handedness: ☐ Right ☐Left ☐ Ambidextrous

CONTACT INFORMATION

Best Time and Place to Reach You: ☐ Morning ☐ Afternoon ☐ Evening ☐ _____
☐ Cell Phone: _____ ☐ Home Phone: _____ ☐ Work Phone: _____
E-Mail Address: _____
IN CASE OF EMERGENCY: Name: _____Phone: _____ Relationship: _____
Whom may we thank for referring you? _____

Employer/School: _____ Occupation: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced
Pregnant: ☐ Yes ☐ No ☐ Separated ☐ Widowed ☐ Minor
If under 18, enter Guardian Info:
Parent/Guardian's Name:_____ Relationship_____
Address: _____City: _____ ST ___ Zip _____Phone:_____

INSURANCE INFORMATION

Responsible Party _____Relationship to Patient _____
Primary Insurance Co: _____ Policy # _____
Secondary Insurance Co: _____ Policy # _____
Insured's Name: _____ Insured's DOB: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to TOTAL LIFE CARE 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. The above named facility may use my information and disclose such information to the above named insurance company for the purpose of obtaining payment for services rendered.

Signature of Patient, Parent or Guardian: _____
Print Name: _____Date _____

What can we do to help you reach your goal?_____

Patient Name: _____Date: _____

CURRENT HEALTH CONDITION

First Complaint (CHOOSE ONLY ONE): ☐ Neck ☐ Mid Back ☐ Low Back ☐ Headaches/Migraines ☐ Shoulder ☐ Wrist/Hands ☐ Knees ☐ Ankle/Foot ☐ Other _____

Is the complaint on your: ☐ Left side ☐ Right Side ☐ Middle ☐ Other _____

Think back, when did your symptoms first appear? Year?_____

Is the condition getting worse? ☐ No ☐ Yes **What makes it worse or what brings it on** (Check all that apply): ☐ Cold ☐ Heat ☐ Sitting ☐ Standing ☐ Laying Down ☐ Repetitive Movement ☐ Stress ☐ Driving ☐ Bending ☐ Lifting ☐ Walking ☐ Other_____

What are you doing that helps? ☐ Ice ☐ Heat ☐ Adjustments ☐ Massage ☐ No Light ☐ No Sound ☐ Drugs for this complaint (☐ Prescription ☐ Over the Counter) ☐ Sleep ☐ Other _____

Describe the complaint (check all that apply): ☐ Burning ☐ Sharp ☐ Throbbing ☐ Pinching ☐ Squeezing ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Deep ☐ Electric Shock ☐ Achy ☐ Dull ☐ Stiff ☐ _____

Does the complaint radiate anywhere? ☐ No ☐ Yes If yes, where? _____

Rate the severity of complaint on scale from 0 (least) **to 10** (most severe)Now __ Average __ Best __Worst __

When do you feel the complaint the most? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ _____

How long does the complaint usually last? (How many?) Hours _____ Minutes _____ ☐ _____

Does this complaint interfere with daily activities? ☐ No ☐ Yes Describe _____

Dr's Notes: _____

_____

Second Complaint (CHOOSE ONLY ONE): ☐ Neck ☐ Mid Back ☐ Low Back ☐ Headaches/Migraines ☐ Shoulder ☐ Wrist/Hands ☐ Knees ☐ Ankle/Foot ☐ Other _____

Is the complaint on your: ☐ Left side ☐ Right Side ☐ Middle ☐ Other _____

Think back, when did your symptoms first appear? Year?_____

Is the condition getting worse? ☐ No ☐ Yes **What makes it worse or what brings it on** (Check all that apply): ☐ Cold ☐ Heat ☐ Sitting ☐ Standing ☐ Laying Down ☐ Repetitive Movement ☐ Stress ☐ Driving ☐ Bending ☐ Lifting ☐ Walking ☐ Other_____

What are you doing that helps? ☐ Ice ☐ Heat ☐ Adjustments ☐ Massage ☐ No Light ☐ No Sound ☐ Drugs for this complaint (☐ Prescription ☐ Over the Counter) ☐ Sleep ☐ Other _____

Describe the complaint (check all that apply): ☐ Burning ☐ Sharp ☐ Throbbing ☐ Pinching ☐ Squeezing ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Deep ☐ Electric Shock ☐ Achy ☐ Dull ☐ Stiff ☐ _____

Does the complaint radiate anywhere? ☐ No ☐ Yes If yes, where? _____

Rate the severity of complaint on scale from 0 (least) **to 10** (most severe)Now __ Average __ Best __Worst __

When do you feel the complaint the most? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ _____

How long does the complaint usually last? (How many?) Hours _____ Minutes _____ ☐ _____

Does this complaint interfere with daily activities? ☐ No ☐ Yes Describe _____

If there are more complaints, please ask for a continuation sheet.

Dr's Notes: _____

_____

Areas Examined: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐Shoulder ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle/Foot

TOTAL LIFE CARE CHARLESTON

Patient Name: _____Date: _____

HEALTH HISTORY

Place a mark on "Past" or "Now" to indicate if you have had any of the following:

AIDS/HIV	☐ Past	☐ Now	**Goiter**	☐ Past	☐ Now	**Pacemaker**	☐Past	☐Now
Alcoholism	☐ Past	☐ Now	**Glaucoma**	☐ Past	☐ Now	**Parkinson's**	☐Past	☐Now
Allergy Shots	☐ Past	☐ Now	**Gonorrhea**	☐ Past	☐ Now	**Pinched Nerve**	☐Past	☐Now
Anemia	☐ Past	☐ Now	**Gout**	☐ Past	☐ Now	**Pneumonia**	☐Past	☐Now
Anorexia	☐ Past	☐ Now	**Heart Disease**	☐ Past	☐ Now	**Prostate Problems**	☐Past	☐Now
Arthritis	☐ Past	☐ Now	**Hepatitis**	☐ Past	☐ Now	**Rheumatoid Arthritis**	☐Past	☐Now
Asthma	☐ Past	☐ Now	**Herniated Disc**	☐ Past	☐ Now	**Stroke**	☐Past	☐Now
Breast Lump	☐ Past	☐ Now	**Herpes**	☐ Past	☐ Now	**Thyroid Problems**	☐Past	☐Now
Bronchitis	☐ Past	☐ Now	**High Cholesterol**	☐ Past	☐ Now	**Tumors**	☐Past	☐Now
Cancer	☐ Past	☐ Now	**Kidney Disease**	☐ Past	☐ Now	**Ulcers**	☐Past	☐Now
Chicken Pox	☐ Past	☐ Now	**Migraine**	☐ Past	☐ Now	**Vaginal Infection**	☐Past	☐Now
Diabetes	☐ Past	☐ Now	**Measles**	☐ Past	☐ Now	**Venereal Disease**	☐Past	☐Now
Emphysema	☐ Past	☐ Now	**Mononucleosis**	☐ Past	☐ Now	**Whooping Cough**	☐Past	☐Now
Epilepsy	☐ Past	☐ Now	**Multiple Sclerosis**	☐ Past	☐ Now	**Other**_____	☐Past	☐Now
Fractures	☐ Past	☐ Now	**Osteoporosis**	☐ Past	☐ Now	_____	☐Past	☐Now

Date of last: Spinal Exam _____ MRI, CT Scan _____

Spinal X-ray _____ Urine Test _____ Blood Test _____

Previous Chiropractic Care? ☐ No ☐ Yes Dr's Name and approximate date of last visit_____

_____ Reason for Change _____

What treatment have you already received for your current condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name of other Doctor(s) who have treated you for this condition _____

Have You Had (List All)	Description	Date(s) Occurred
Motor Vehicle Accidents (all, including fender benders)		
Broken Bones		
Dislocations:		
Head Injuries:		
Falls (down the stairs, off a bike, tripped, etc.)		

Any Surgeries? ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Back Surgery ☐ Cancer _____

☐ Hernia ☐ Wisdom Teeth ☐ Heart (describe) _____ ☐ C-Section _____# of times

☐ Hysterectomy Other _____ _____

ACCIDENT INFORMATION

Please notify receptionist if the reason for your visit is due to an accident.

Is condition due to an accident: ☐ No ☐ Yes If so, then date of Accident: _____

Type of Accident (Car, Bike, Fall, etc): _____

Bill to: _____ Attorney Name _____

TOTAL LIFE CARE CHARLESTON

Patient Name: _____Date: _____

Exercise	Daily Activity	Habits
☐ None	☐ Sitting	☐ Smoking Packs/Day_____
☐ Moderate ____x/wk	☐ Standing	☐ Alcohol Drinks/Week or Month_____
☐ Daily	☐ Light Labor _____lbs	☐ Caffeine (coffee/tea/soda) 8 oz Cups/Day_____
☐ Heavy	☐ Heavy Labor_____ lbs	☐ Stress (family/spouse/kids/school/work/life/money/all)

_____ _____

CURRENT MEDICATIONS/ALLERGIES

Medications/Drugs	Reason For Taking	Allergies
_____	_____	Seasonal ☐ Yes ☐ No
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FUNCTIONAL DAILY LIVING

Are You Having Problems with the motions involved with these or other activities:

Travelling	☐ Y ☐ N	Ex: Driving (sitting, turning head, in/out of car)_____
Grooming	☐ Y ☐ N	Ex: Showering, Dressing, Putting on Socks/Shoes_____
Yard Work	☐ Y ☐ N	Ex: Gardening (kneeling, bending, lifting) _____
Exercising	☐ Y ☐ N	Ex: Walking, Climbing Stairs, Carrying Groceries_____
Housework	☐ Y ☐ N	Ex: Vacuuming (pushing/pulling), Loading Dishwasher_____
Sleeping	☐ Y ☐ N	Ex: Laying Down, Turning Over, Getting Up _____

FAMILY HISTORY

	Arthritis	High Blood Pressure	Cancer/Type	Diabetes	Epilepsy	Other/Type (Heart Disease, Alzheimer's)
Self	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Mother	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Father	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Maternal GM	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Maternal GF	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Paternal GM	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Paternal GF	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Sibling - a	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Sibling - b	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____
Sibling - c	☐ Y ☐ N	☐ Y ☐ N	☐ Y _____☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N _____

I certify that the information contained within this form is correct to the best of my knowledge, and I understand that all payments are due at the time of service unless other arrangements have been made.

Patient/Parent/Guardian Signature _____ Date _____

X-RAY

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time to the best of my knowledge I am NOT pregnant, and I consent to radiographic pictures if necessary.

Patient Signature _____ Date _____

TOTAL LIFE CARE CHARLESTON

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

The availability and nature of other treatment options which may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. S Latter, Dr. H Latter, or Dr. A Hall, and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient Name (printed) Date

_____ _____
Patient Signature (or legal Guardian) Relationship to Patient

_____ _____
Witness Signature (office staff) Date

TOTAL
LIFE CARE
CHARLESTON

Appointment Scheduling Policy

Thank you for taking advantage of the services we offer at Total Life Care! We make every attempt to provide the best services at fair prices. To do this we ask that you keep your appointments for Chiropractic, Nutrition, and/or Massage as scheduled. The Doctor's and Massage Therapists schedule a portion of their time to spend with you. If you cannot keep your appointment, please call our office at 843-402-0310 with at least a 24-hour notice. Failure to cancel your appointment within that time frame may result in a charge of $20.00*.

Also, if you are late for your scheduled massage appointment, you will receive the remaining time of your massage, but will still be billed for the amount of time which you originally scheduled your massage.

I understand that this policy is valid for any appointment I schedule at Total Life Care Charleston effective from this date until such time I am released from care of this office.

I understand the scheduling policy of Total Life Care Charleston.

_____ _____

Patient Signature Date

_____

Please Print Name

* PLEASE NOTE: This cancellation fee is <u>not</u> charged to your insurance company, and will be billed directly to you.

THIS FORM IS NOW REQUIRED BY THE UNITED STATES GOVERNMENT UNDER HIPPA REGULATIONS

Notice of Privacy Practices for Protected Health Information

A. Uses and Disclosures **B. Appointment Reminders** **C. Marketing** **D. Fund Raising**

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

A. Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provided appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii) (A). If you are not at home or work to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will no affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

B. Appointment Reminders

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

C. Marketing

From time to time our practice works with marketing organizations we will never use any information about you without your written approval. This form does not give that approval. If we ever decide to use information from or about you, another form detailing what information we want to use and for what purpose will be presented for your approval.

You have the right to refuse to give us authorization to contact you for marketing purposes. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

D. Fund Raising

From time to time our practice works with charity organizations we will never use any information about you without your written approval. This form does not give that approval. If we ever decide to use information from or about you, another form detailing what information we want to use and for what purpose will be presented for your approval.

You have the right to refuse to give us authorization to contact you for fund raising purposes. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you about fund raising efforts at any time. Our practice and staff will receive direct or indirect remuneration from our fund raising activities.

Our Privacy Pledge

We have an always will respect your privacy. Other than the uses and disclosures we described above, <u>we will not sell or provide any of your health information to any outside marketing organization.</u>

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:
   TOTAL LIFE CARE CHARLESTON, LLC 825 Wappoo Road, Charleston, SC 29407

Your right to limit uses or disclosures
If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information
We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information
You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and /or copy your health information to be in writing.

Your right to amend your health information
You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records
You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain
You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to: TOTAL LIFE CARE 825 Wappoo Road, Charleston, SC 29407

To contact us
If you would like further information about our privacy policies and practices please contact: TOTAL LIFE CARE CHARLESTON, LLC 825 Wappoo Road, Charleston, SC 29407

PRIVACY NOTICE ACKNOWLEDGEMENT
We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I have read and understand the Patient Privacy Procedures of TOTAL LIFE CARE CHARLESTON, LLC.

_____ _____

Patient Signature **Date**