WELCOME

formPI033022

Date _____ Patient Number_____

Name_____ M/F Date of Birth _____SS#_____

Address_____

City_____ State____ Zip Code_____ Email_____

Cell_____ Hm. _____ Wk._____ Employer_____

Emergency Contact Name_____ Emergency Contact #_____

Name of nearest relative not living with you:_____ Phone #_____

Payment Responsibility Acknowledgement

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Also, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment. I understand that all sales on durable medical equipment are final. I understand that health insurance contracted rate does not apply. I completely understand that if I choose to terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. Also, I understand and agree to reimburse this office for any and all collection fees, attorney fees, court costs, and filing fees for any reason including the event of default or failure to pay the balance.

Patient's Signature: _____

Informed consent of examination and release of information

I hereby authorize the doctor and whom ever he may designate as his assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case or my minor child's case. I understand that the examination is to include information about myself and my personal circumstances, as well as my health. I understand that the examination is not intended to do harm or cause pain. Although the purpose of the examination is to duplicate my complaints. This may cause discomfort or pain. Because of this factor, I should not perform any task beyond what I can normally and physically tolerate. I understand that it is my responsibility to inform the examining physician of my limitations and hesitations. I understand that the results of this evaluation may not be made known to me at the time of the completion of the evaluation. I authorize the doctor and staff to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable to the clinic or to the patient or to a family member or employer or the patient for all or part of the charges, including, and not limited to hospital, or medical services companies, insurance companies, workers compensation carriers, welfare fund or the patient's employer. I authorize treatment of my minor child without my presence. I authorize my attorney to disclose all information on my case to this office.

Patient's Signature: _____

APPOINTMENT CANCELLATION POLICY

I hereby understand with my signature, that if I do not cancel my appointment twenty-four hours prior to the appointment, I will be charged a no-show fee of $100. I understand that I am solely responsible for this payment and that it is not the responsibility of my insurance company, third party payer, PIP coverage, workers compensation carrier, or my attorney.

Patient's Signature _____Date _____

DISCLOSURE OF FEE/PAYMENT POLICY

99201-25	NEW PATIENT MINOR EXAM	$85.00
99202-25	NEW PATIENT PROBLEM FOCUSED EXAM	$175.00
99203-25	NEW PATIENT DETAILED HISTORY EXAM	$300.00
99211-25	ESTABLISHED PATIENT MINOR EXAM	$45.00
99212-25	EST. PATIENT PROBLEM FOCUSED EXAM	$60.00
99213-25	EST. PATIENT DETAILED HISTORY EXAM	$195.00
98940	SPINAL ADJUSTMENT, 1-2 LEVELS	$55.00
98941	SPINAL ADJUSTMENT, 3-4 LEVELS	$59.00
98942	SPINAL ADJUSTMENT 5 OR MORE LEVELS	$69.00
98943	EXTREMITY ADJUSTMENT	$39.00
97022	HYDROTHERAPY	$59.00
97012	INTERSEGMENTAL TRACTION	$49.00
97026	INFRARED THERAPY	$49.00
G0283	ELECTRIC MUSCLE STIMULATION	$49.00
97035	ULTRASOUND THERAPY	$39.00
A4456	ELECTRODES	$16.00
S9090	SPINAL DECOMPRESSION	$150.00
E0730-NU	TENS UNIT	$195.00
99080	FMLA/DISABILITY FORMS	$25.00
99080	CERTIFIED LETTER	$15.00

I have read the above codes and fees and understand the cost of my care at KFCA, PA. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand that therapies are billed in quarter hour increments. I understand that I will be billed for each service performed. I understand that this is a partial list of services rendered and is subject to change without notice. I understand that most insurance policies do not cover spinal decompression. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 25% of the outstanding balance whichever is greater. If my balance is not paid in a timely fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I understand that any transaction on my account including but not limited to charges, payments, collection agency fees, and attorney fees will re-age my account and the statute of limitations will begin on the date of the last transaction. I further understand that if my treatment is associated with personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that health insurance contracted rate does not apply. I understand that I am responsible for verifying my insurance. I understand that my balance with KFCA, PA may be sold, transferred, or assigned to another party I understand that if a check or debit is returned for insufficient funds, I will be charged a $35.00 service charge.

I have read and fully understand the above financial terms and prices.

Patient's Signature_____Date_____

NOTICE OF INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic are before consenting to treatment. This is called an informed consent.

A subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of its normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral subluxations with spinal adjustments (performed by hand or with the use of a specific tool) in order to reposition the misaligned segments. Frequently, adjustments create a popping sound or clicking sensation in the area being treated. This sound is the release of gas that has been created by suction in the joint.

In this office we use highly trained staff to assist the doctor with portions of your consultation, examination, x-ray, physiotherapy, traction, massage, exercise instruction, etc. Occasionally, when your doctor is not available another clinic doctor will treat you in his place.

Stroke: Stroke is the most serious problem associated with spinal adjustments, regardless of whether the provider is a chiropractor or medical physician. A stroke occurs when a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with a much rarer complication of death. Spinal adjustments have been associated with strokes that arise from the vertebral artery. The specific neck adjustment that is related to this complication is not performed in this office. The most recent studies (Journal of the California Chiropractic Association Vol.37, No. 26-93) estimates that the incidence of this type of complication occurring is 1(one) in every 3,000,000 (three million) adjustment to the neck. This means that the average chiropractor would have to practice for over 100 years before they would be statistically associated wit ha single patient stroke.

The most effective method of lessening the odds that a patient is prone to a stroke is through careful screening of risk factors in the history, including medications taken, as well as a family history of high blood pressure and specific exam procedures to assess blood flow to the brain.

Disc Herniation: Disc herniations that create pressure on nerves, or the spinal cord, are frequently treated successfully by chiropractors using adjustments, distraction, and other therapies. This includes both in the neck and the low back. Occasionally chiropractic treatment will aggravate this problem. To help prevent this, patients are put through specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Due to the fact of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones and ligaments limiting joint movement. Rarely, a chiropractic adjustment, traction, massage, etc. may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution, with no long-term affects to the patient. These problems occur so rarely that there is no available statistics to quantify their probability.

Rib Fracture: The ribs are found attached to the thoracic spine in the middle of the back. They extend from your back to the front of your chest. Rarely, a chiropractic adjustment may break a rib, this is referred to as a fracture. This occurs in those patients who have weakened bones form such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. This can be ruled out in the history or x-rays. We adjust all patients carefully and especially those with bone weakened conditions. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is a temporary increase in skin pain and possibly some blistering. These problems occur so rarely that there is no available statistics to quantify their probability.

Soreness: It is common for spinal adjustments, distraction, massage, exercise, etc. to result in a temporary increase in soreness in the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous but do tell the doctor or staff member about it.

Other Problems: There may be other problems or complications that may arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated allows the formation of adhesions and reduces mobility, which sets 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. The probability that non-treatment will complicate a later rehabilitation is very high.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we can not promised a cure for all symptoms, disease, or conditions as a result of treatment at this facility. We will always give you the best care that we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

I hereby authorize the doctor(s) or assistants in this office to perform upon my examination and diagnostic procedures arising from current or presently unforeseen conditions. I understand that this office has the right to refuse to accept me as a patient at anytime before treatment begins. The taking of a history and conduction of a physical examination are not considered treatment but are part of the process of information gathering so that the doctor(s) can determine whether to accept me as a patient.

If you have any questions on the above information, please ask your doctor to explain them more fully. When you have a full understanding of this material, please sign and date this document below and then return it to the front desk or doctor.

_____ _____/_____/_____
Patient's Signature Date

_____ _____
Patient's Name Parent/Guardian's Signature

_____ _____/_____/_____
Witness Date

IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____County, state of Texas, do appoint my healthcare provider Dr. Ronald Faries (hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any auto insurance, health insurance, or 3rd party liability insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all auto, health, or liability insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Dated: _____, 20_____

_____ (Signature of Principle)

_____ (Printed Name of Principle)

STATE OF TEXAS
COUNTY OF TARRANT

On _____, 20_____, before me_____personally appeared, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____

PAYMENT, LIEN AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO KFCA, PA

Form 070715B

Purpose. The purpose of this Assignment & Lien is to assist the Office in obtaining Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to KFCA, PA located at PO Box 1243, Keller, TX 76244-1243; "Assignment Lien Document," "Assignment & Lien," and administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds and/or benefits, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds and/or benefits, either now or in the future; "Proceeds and/or benefits" shall include without limit, the proceeds and/or benefits from any settlement, judgment, or verdict, the proceeds and/or benefits from, any promise to pay or reimburse, the proceeds relating to "health-ca-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code and the proceeds and/or benefits relating to the following benefits, plan or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protector lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges: shall include equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), or any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (12%), whichever is greater, and any other charges incurred by me at the Office' "Collection Costs" shall include without limit any pre- and post judgment court costs, filing gees, service of process charges, attorneys fees or costs associated with requests for consideration, independent reviews, appeals, mediation, arbitration, and another costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien **Terms.** I hereby assign, grant, and convey to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds and/or benefits, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my conditions ("Claims to Proceeds and/or benefits"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds and/or benefits wither in my name or in the Office's name and as the Office otherwise sees fit. I agree that his assignment shall be effective as of the date and time of the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds and/or benefits to the extent permitted by law for the purpose f securing payment of my charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filled with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charge to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds and/or benefits directly to, immediately to, and exclusively in the name of, the office to the full extent of my Charges. To the extent that any law, including without limit a lien salute, purports to limit, reduce, or modify the distribution of Proceeds and/or benefits in any manner inconsistent with this Assignment & Lien including without limit throughout the reservation of a portion of the proceeds and/or benefits exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds and/or benefits from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds and/or benefits, to promptly pay the Office in-full out of such Process, and to provide immediate notice to the Office regarding such Proceeds and/or benefits, and to provide a full accounting of such Proceeds and/or benefits to the Office, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds and/or benefits to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives. I hereby direct any and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (Proceeds and/or benefits Determination by the Payer request to the Office's Changes. "Pertinent Information" shall include without limit the amount of the total coverage available and relating, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertaining Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds and/or benefits Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds and/or benefits Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds and/or benefits Determination" shall include without limit any determination by record, or other information was relied upon in making the Proceeds and/or benefits relating to the Office's Charges, as well as a decision to refer he Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed document but only to the extent those terms conflict with the terms of their Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located and is performable in the county where the Office is located. In any action based upon this Agreement & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name(Print)_____

Patient Signature: _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print):

_____

Parent/Guardian Signature: _____ Date: ___/___/___

SWORN AND SUBSCRIBED before me on the _____ day of _____, 2021

Notary's Signature: _____

Notary's Printed Name: _____

Notary Public, State of: _____

Commission Expires: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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:

- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/01/2008 will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose if you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification, of (including identifying or locating) a family member, your present representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use or disclose your health information for marketing communications without your written authorization

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you the amount allowed under the Texas Administrative Code, Title 22, part 3, chapter 80, rule 80.3. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once a 12 month period we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be n writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerns that we have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosures of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer	Ronald Faries, D.C. , FABDA, FAAIM, DAAIM
Telephone	817-431-2210
Address	PO Box 1243
	Keller, TX 76244-1243