

# WELCOME

## Trinity Pain Relief Center Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) & PHOTO ID**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_ Phone \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any allergies (meds, foods, seasonal): \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
|  | <input type="checkbox"/> Other _____     |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

**HEAD**

- Headache
- Entire head
- Back of head
- Forehead
- Temples
- Migraine
- Head feels heavy
- Loss of memory
- Light headedness
- Fainting
- Pain in eyes
- Light bothers eyes
- Loss of smell
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

**NECK**

- Pain in neck
- Neck pain without movement
- Neck feels out of place
- Stiff neck
- Muscle spasms in neck
- Grinding sounds in neck
- Grating sounds in neck
- Popping sounds in neck
- Pinched nerve in neck

**SHOULDERS**

**PAIN IN:**

- Right shoulder
- Left shoulder
- Both shoulders
- Pain across shoulders

**CAN'T RAISE ARMS ABOVE:**

- Shoulder level
- Head
- Tension in shoulders

**MID BACK**

- Mid back pain
- Pain between shoulder blades
- Sharp stabbing pain in mid back
- Muscle spasms in mid back

**CHEST**

- Chest pain
- Shortness of breath

**PAIN AROUND**

- Right rib
- Left rib
- Both ribs

**WOMEN ONLY**

- Menstrual pain
- Cramping with menstrual pain
- Irregularity of menstruation

**ARMS & HANDS**

**PAIN IN:**

- Right upper arm
- Left upper arm
- Both upper arms
- Right forearm
- Left forearm
- Both forearm
- Right wrist
- Left wrist
- Both wrists
- Right hand
- Left hand
- Both hands
- Right fingers
- Left fingers
- Both left and right fingers

**SENSATION OF PINS & NEEDLES:**

- Right arm
- Left arm
- Both arms
- Right fingers
- Left fingers
- All fingers
- Hands cold

**SWOLLEN JOINTS IN:**

- Right fingers
- Left fingers
- All fingers

**SORE JOINTS IN:**

- Right fingers
- Left fingers
- All fingers

**LOSS OF GRIP STRENGTH IN:**

- Right hand
- Left hand
- Both hands

**GENERAL**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally run down
- Loss of sleep
- Loss of weight

**LOW BACK**

- Low back pain

**LOW BACK PAIN WORSE WHEN:**

- Working
- Lifting
- Stooping
- Standing
- Sitting
- Bending
- Coughing
- Lying down
- Low back feels out of place
- Muscle spasms in lower back

**TEMPORMANDIBULAR JOINT**

- Pain in TMJ

**HIP, LEG & FEET**

**PAIN IN:**

- Right Buttocks
- Left Buttocks
- Both Buttocks
- Right Hip Joints
- Left Hip Joints
- Both Hip Joints

**PAIN DOWN:**

- Right Leg
- Left Leg
- Both Legs

**PAIN IN**

- Right knee
- Left knee
- Right ankle
- Left ankle
- Right foot
- Left foot
- Leg Cramps

**SENSATION OF PINS & NEEDLES IN:**

- Right leg
- Left leg
- Both legs

**NUMBNESS OF:**

- Right leg
- Left leg
- Both legs
- Right foot
- Left foot
- Both feet
- Right toes
- Left toes
- All toes
- Right foot feels cold
- Left foot feels cold
- Both feet feel cold

**CRAMPS IN:**

- Right foot
- Left foot
- Both feet

**SWOLLEN:**

- Right knee
- Left knee
- Right ankle
- Left ankle
- Right foot
- Left foot

**PAINFUL JOINTS IN:**

- Right toes
- Left toes
- All toes

**ABDOMEN**

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea

Name \_\_\_\_\_

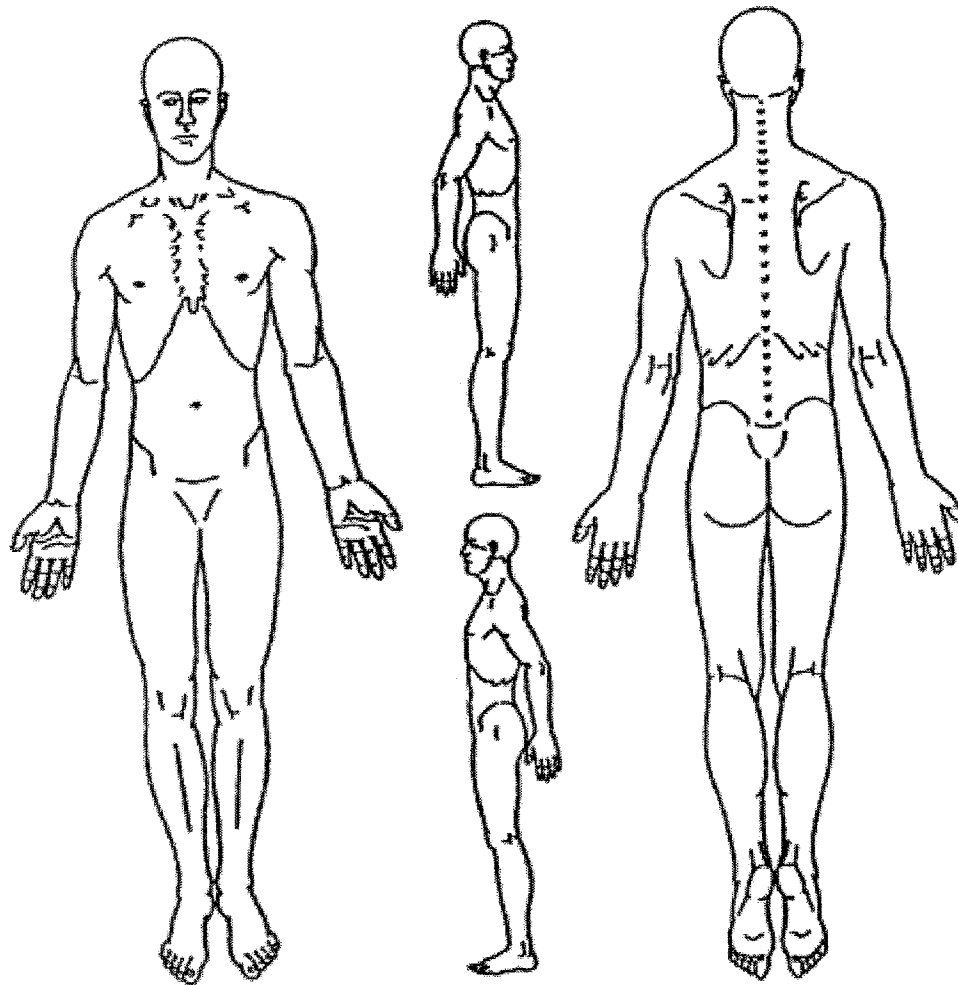
Date \_\_\_\_\_

# SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

### KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## NEUROLOGICAL AND VASCULAR QUESTIONNAIRE

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

For any YES answer, please notify the Doctor:

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arm or hands?     | NO | YES |
| Comment: _____  |    |     |
| 2. Do have weakness, numbness or burning in your shoulder, arms or hands?     | NO | YES |
| Comment: _____  |    |     |
| 3. Do your hands or arms fall asleep regularly?                               | NO | YES |
| Comment: _____  |    |     |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms? | NO | YES |
| Comment: _____  |    |     |
| 5. Do you suffer from a loss of handgrip strength?                            | NO | YES |
| Comment: _____  |    |     |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?     | NO | YES |
| Comment: _____  |    |     |
| 7. Do have weakness, numbness or burning in your buttocks, legs or feet?      | NO | YES |
| Comment: _____  |    |     |
| 8. Do your legs or feet fall asleep regularly?                                | NO | YES |
| Comment: _____  |    |     |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?    | NO | YES |
| Comment: _____  |    |     |
| 10. Do you suffer from cold hands or feet?                                    | NO | YES |
| Comment: _____  |    |     |
| 11. Do you suffer from headaches, dizziness or memory loss?                   | NO | YES |
| Comment: _____  |    |     |
| 12. Do you have difficulty maintaining your balance?                          | NO | YES |
| Comment: _____  |    |     |
| 13. Do you suffer from vertigo or blurred vision?                             | NO | YES |
| Comment: _____  |    |     |
| 14. Do you suffer from reduced hearing capacity?                              | NO | YES |
| Comment: _____  |    |     |
| 15. Do you suffer from ringing in your ears?                                  | NO | YES |
| Comment: _____  |    |     |
| 16. Do you have bladder or bowel control problems on a regular basis?         | NO | YES |
| Comment: _____  |    |     |

**NOTE: Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurer, your health information on this form may be shared with the insurer. Your health information which the insurer sees will be kept confidential by the insurer.

# TRINITY PAIN RELIEF CENTER

## Patient Financial Program

**On-The-Job-Injury:** I was injured at work and this claim is being submitted under my employer's Worker's Compensation Insurance. In the event that this claim should be rejected by that carrier, I understand that I am liable for payment of all treatments and services. Patients Initials \_\_\_\_\_

**Auto Accident:** I was injured in an auto accident and this claim is being submitted through auto insurance. In the event this claim should be rejected by that carrier, I understand that I am liable for payment of all treatments and services. Patient Initials \_\_\_\_\_

**Insurance Assignment:** I have insurance and will make assignment to the doctor and/or clinic. Patients Initials \_\_\_\_\_

DEDUCTIBLE: My deductible is \$ \_\_\_\_\_

I have met my deductible for the current year.

I haven't met my deductible for the current year & will pay \$ \_\_\_\_\_ on \_\_\_\_\_

ESTIMATED PATIENT PORTION: In addition to my deductible, I understand that I am responsible for any amount not covered by my insurance policy(s). I will pay the Estimated portion of my bill on a WEEKLY basis.

Patients Initials \_\_\_\_\_

REDUCTIONS AND REJECTIONS OF CLAIMS BY MY INSURANCE CARRIER DO NOT IN ANY WAY AFFECT MY OBLIGATION TO PAY THE BILL IN FULL.

**Cash Agreement:** I will make payment in full for services rendered on my first visit and on a weekly basis thereafter. Patients Initials \_\_\_\_\_

ALTERNATIVE METHODS OF PAYMENT: VISA, MATERCARD, AMERICAN EXPRESS, DISCOVER

I understand that I will be charged for missed appointments unless I give adequate notice of at least at 24 hour period. Patients Initials \_\_\_\_\_

**NOTICE:** One Point five percent (1.5%) interest is charged on all unpaid balances carried over thirty (30) days. Accounts sixty (60%) days past due without written financial arrangements are immediately sent for collection. I agree to pay all reasonable court cost and attorney fees should I default on my account.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on 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 payment. I also understand that if I suspend or terminate my care for treatment, any services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of medical care or spinal adjustments. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while the patient is at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

I authorize the Doctors and Staff of Trinity Pain Relief Center, LLC to administer such procedures and treatment as they deem necessary to my (son) (daughter) (ward in my legal custody).

**The Clinic, Doctors, and Staff have implied no guarantee of cure.**

I have read and agree to abide by the terms set above.

**PATIENTS**

**SIGNATURE** \_\_\_\_\_

**Date** \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_

**Date** \_\_\_\_\_



## NOTIFICATION OF NEW POLICY ON CANCELLATION OF APPOINTMENTS

We now require a 24-hour notice for cancelled appointments. If appointments are not cancelled by the notice required, there will be a fee of \$30, which must be paid before your next office visit.

This change will allow us to offer open appointment times to other patients who may need them.

We appreciate any help you can give us in this matter. We appreciate your business.

Dr. Genia Fraser Sword & Dr. Stacy Roberts

By signing below, I am stating that I understand and agree to the  
aforementioned statements and terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Trinity Pain Relief Center, LLC.**

**CONSENT TO TREAT**

I hereby authorize the Doctors at **Trinity Pain Relief Center, LLC.** to treat my case as they deem appropriate through the use of medical care, physical therapy, rehabilitation, manual therapy, chiropractic adjustments of the spine and extremities, nutritional support, trigger point injections, large joint injections and diagnostic testing. I realize the goal of holistic healthcare is to naturally strengthen the patient's body in order for the body to better heal itself and not to treat a particular condition or disease. I also realize this office offers alternatives to holistic care in the form of traditional medical care and that I may elect to receive those services as well. This office will not assume responsibility of treatment of any particular conditions or disease.

It is understood and agreed the amount paid to the clinic for x-rays is for cost of materials and interpretation and the x-ray originals will remain the property of this office for a period of 10 (ten) years, pursuant to Georgia law. The patient will be entitled to a written report of x-ray findings. The patient also agrees that he/she is responsible for all bills incurred at this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# HIPAA Notice of Privacy Practices

Effective as of April 14, 2003



**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnosis or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a diagnostic testing, may require that your relevant protected health information be disclosed to the health plan to obtain approval for the testing

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceeding, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

UPDATED 02/2010

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS ARE EXPLAINED BELOW:**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (FEES MAY APPLY)** – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of or used in, a civil, criminal, or administrative action or proceedings, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS:**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.**

**Please sign the accompanying "Acknowledgement" form. Please note that by signing the acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

# HIPAA NOTICE OF PRIVACY PRACTICES

## ACKNOWLEDGMENT FORM

Signature below is only acknowledgement that you received the HIPAA Notice of our Privacy Practices:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PERMISSION TO LEAVE A MESSAGE

By signing below, I am giving Trinity Pain Relief Center permission to leave appointment reminders on my home/cell answering machine/voicemail. If a live person answers the phone, Trinity Pain Relief Center has my permission to leave a message with the person answering the phone.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### PERMISSION TO SHARE HEALTH INFORMATION

By signing below, I am authorizing Trinity Pain Relief Center to discuss my health information with the following persons, if necessary. This authorization will remain in effect unless I revoke permission in writing.

Persons authorized to receive health information:

1. \_\_\_\_\_  
Print Name Relationship to Patient Phone Number & Type (C, W, H)

2. \_\_\_\_\_  
Print Name Relationship to Patient Phone Number & Type (C, W, H)

3. \_\_\_\_\_  
Print Name Relationship to Patient Phone Number & Type (C, W, H)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**NO SIGNATURE REQUIRED IF PERMISSION TO SHARE HEALTH INFORMATION IS LEFT BLANK**