

# Application for Care at Tinker Family Chiropractic

Today's Date: \_\_\_\_\_ HRN: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

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

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF PHYSICAL COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_  
 Secondly: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

## QUADRUPLE VISUAL ANALOG SCALE

Please circle the number that best describes the question being asked. If you have more than one complaint/condition above, indicate the score for each one. **See example below:**



What is your pain RIGHT NOW?  
 0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?  
 0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?  
 0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS WORST (How close to "10" does your pain get at it's worst)?  
 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant  I experience it on and off during the day  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_ Is your problem a result of ANY type of accident ( YES or NO )

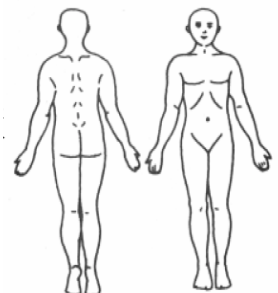
Have you been treated for this in the past?  No  Yes **If yes,** when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_ ( I've never been to a chiropractor)

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = Radiating B = Burning D = Dull A = Aching N = Numbness**  
**S = Sharp/ Stabbing T = Tingling**



What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_

Patient's Name: \_\_\_\_\_

HR#: \_\_\_\_\_

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

**DAILY ACTIVITIES: Effects of Current Conditions On Performance**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

**INITIAL NERVE SYSTEM PROFILE**

When was your most recent auto accident? \_\_\_\_\_

What speed was the collision? \_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_

When was your most recent strain / stress at work? \_\_\_\_\_

Please describe the manner of the injury \_\_\_\_\_

Was treatment received? Please describe \_\_\_\_\_

Does your job require you remain in long term stressful postures? \_\_\_\_\_

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past:

- Collision, quick burst, or repetitive motion sports (football, wrestling, basketball, baseball, soccer, tennis, golf, track/field)?

( YES or No ) Please describe: \_\_\_\_\_

-Trauma as a child? (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident)?

( YES or No ) Please describe: \_\_\_\_\_

- Work around the house – lifting, bending, woke up with stiff neck, "back went out"?

( YES or No ) Please describe: \_\_\_\_\_

- Any other traumas not listed above? \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

Patient's Name: \_\_\_\_\_

HR#: \_\_\_\_\_

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

**Please mark P for in the Past, C for Currently have and N for Never**

- \_\_\_ Headache      \_\_\_ Pregnant (Now)      \_\_\_ Dizziness      \_\_\_ Prostate Problems      \_\_\_ Ulcers
- \_\_\_ Neck Pain      \_\_\_ Frequent Colds/Flu      \_\_\_ Loss of Balance      \_\_\_ Impotence/Sexual Dysfun.      \_\_\_ Heartburn
- \_\_\_ Jaw Pain, TMJ      \_\_\_ Convulsions/Epilepsy      \_\_\_ Fainting      \_\_\_ Digestive Problems      \_\_\_ Heart Problem
- \_\_\_ Shoulder Pain      \_\_\_ Tremors      \_\_\_ Double Vision      \_\_\_ Colon Trouble      \_\_\_ High Blood Pressure
- \_\_\_ Upper Back Pain      \_\_\_ Chest Pain      \_\_\_ Blurred Vision      \_\_\_ Diarrhea/Constipation      \_\_\_ Low Blood Pressure
- \_\_\_ Mid Back Pain      \_\_\_ Pain w/Cough/Sneeze      \_\_\_ Ringing in Ears      \_\_\_ Menopausal Problems      \_\_\_ High Cholesterol/Triglycerides
- \_\_\_ Low Back Pain      \_\_\_ Foot or Knee Problems      \_\_\_ Hearing Loss      \_\_\_ Menstrual Problem      \_\_\_ Difficulty Breathing
- \_\_\_ Hip Pain      \_\_\_ Sinus/Drainage Problem      \_\_\_ Depression      \_\_\_ PMS      \_\_\_ Lung Problems
- \_\_\_ Back Curvature      \_\_\_ Swollen/Painful Joints      \_\_\_ Irritable      \_\_\_ Asthma      \_\_\_ Kidney Trouble
- \_\_\_ Scoliosis      \_\_\_ Skin Problems      \_\_\_ Mood Changes      \_\_\_ Learning Disability      \_\_\_ Gall Bladder Trouble
- \_\_\_ Numb/Tingling arms, hands, fingers      \_\_\_ ADD/ADHD      \_\_\_ Eating Disorder      \_\_\_ Liver Trouble
- \_\_\_ Numb/Tingling legs, feet, toes      \_\_\_ Allergies      \_\_\_ Trouble Sleeping      \_\_\_ Hepatitis (A,B,C)
- \_\_\_ Broken Bone      \_\_\_ Dislocations      \_\_\_ Tumors      \_\_\_ Rheumatoid Arthritis      \_\_\_ Fracture
- \_\_\_ Heart Attack      \_\_\_ Osteoarthritis      \_\_\_ Cerebral Vascular      \_\_\_ Disability      \_\_\_ Diabetes/Prediabetes
- \_\_\_ Cancer (Type: \_\_\_\_\_)      \_\_\_ Other conditions/diagnoses not listed: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

**Does anyone in your family suffer with the same condition?**  No  Yes **If yes, whom?** \_\_\_\_\_

Have they ever been treated for their condition?  No  Yes  I don't know

**Any other hereditary conditions the doctor should be aware of.**  No  Yes: \_\_\_\_\_

**List Prescription & Non-Prescription drugs or supplements you take:** \_\_\_\_\_

\_\_\_\_\_

I hereby authorize payment to be made directly to Tinker Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Tinker Family Chiropractic or any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

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

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_  
**Date Form Reviewed**

Patient's Name: \_\_\_\_\_

HR#: \_\_\_\_\_

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

**Do you smoke?**  No  Cigars  Pipe  Cigarettes How often?  Daily  Weekends  Occasionally  Never  Quit on \_\_\_\_\_

**Do you drink alcoholic beverages?**  Daily  Weekends  Occasionally  Never

**Do you use recreational drugs?**  Daily  Weekends  Occasionally  Never

### **INITIAL NUTRITIONAL PROFILE**

Do you eat breakfast daily from Monday to Friday? *YES or NO*

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (*circle all that apply*)

Diet Soda      Coffee      Juice      Milk      Soda      Alcohol

### **INITIAL FITNESS PROFILE**

How many times per week do you exercise? \_\_\_\_\_

Cardiovascular \_\_\_Hours \_\_\_Days/Wk      Weight Training \_\_\_Hours \_\_\_Days/Wk

Low Impact (Yoga, etc.) \_\_\_Hours \_\_\_Days/Wk

What is your target weight? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

### **INITIAL TOXICITY PROFILE**

Are you regularly exposed to cleaning products or industrial chemicals? *YES or NO*

Have you ever noticed mold growing in your home or your place of work? *YES or NO*

Does your home, work, school, or car have damp or mildew smell? *YES or NO*

Have you received a full standard profile of vaccinations? *YES or NO*

Do you receive yearly flu shots? *YES or NO*      How many flu shots have you received? \_\_\_\_\_ (estimate)

Have you been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? *YES or NO*

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? *YES or NO*

### **INITIAL STRESS PROFILE**

Do you average less than 7 hours of sleep per night? *YES or NO*

Do you ever take pills to go to sleep or relax? *YES or NO*

Do you often feel short on time and procrastinate on projects? *YES or NO*

Do you experience feelings of anxiety about completing tasks? *YES or NO*

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? *YES or NO*

Do you rely more on your memory than a planner and action list to get things done? *YES or NO*

Do you take time to pray, meditate, or visualize on a regular basis? *YES or NO*

How willing are you to change any of these things to reach your health goals? (**Scale of 1-10**) \_\_\_\_\_

**Looking out 6-12 months, what would your ultimate health goal be?** \_\_\_\_\_

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*We are here to help you reach your God-given potential, in Health and in Life!! We look forward to helping you reach your health goals!*

# Informed Consent

## **REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Tinker Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  *Witness Initials*  
Patient or Authorized Person's Signature Date

## **REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY** → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  *Witness Initials*  
Patient or Authorized Person's Signature Date

**JDD,DC 5/2011**

# TINKER FAMILY CHIROPRACTIC

## Release of Information

Your privacy is very important to us, please list any person/persons to whom we may discuss your chiropractic care, financial, and or any issues dealing with your health.

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone # \_\_\_\_\_

The following names above have permission to speak with Dr. Brittany Tinker and or staff concerning my care and or finances.

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

***Tinker Family Chiropractic's Office Policies***

*I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.*

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

***Tinker Family Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....***

I have received a copy of Tinker Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	





# OUR OFFICE POLICIES

## Welcome to Tinker Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Tinker Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Diversified Full Spine, Thompson, Activator, and Arthrostim. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

# Tinker Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

## PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

## YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

## COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Tinker at (615) 948-3790 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201