



**THE CENTER FOR FAMILY WELLNESS**

7533 South Memorial Parkway ~ Suite B

Huntsville, Alabama 35802

Phone: 256-880-6199 ~ Fax: 256-880-3736

ANNE CAIN, LMT 563

KELLY L. FARRELL, LMT 1542

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

Are you currently under care of a physician? Yes  No

Reason: \_\_\_\_\_

Are you currently under care of a chiropractor? Yes  No

Dr. Omenski \_\_\_\_\_ Dr. Aplin \_\_\_\_\_ Other \_\_\_\_\_

Date of last adjustment: \_\_\_\_\_

Any *serious* injuries? What, when and residual effect?

\_\_\_\_\_

Any surgeries? What, when and residual effect?

\_\_\_\_\_

Any *serious* illness? What, when and residual effect?

\_\_\_\_\_

Any *allergies*? (Medicines, topical, seasonal, etc.) \_\_\_\_\_

Are you under the care of any other health professionals?

\_\_\_\_\_

Are you under any *unusual* stress?

\_\_\_\_\_

Do you exercise or have regular activities? Yes  No

What activities do you participate in? How often?

\_\_\_\_\_

Do you have any areas of tension in your body? Are these considered chronic or acute?

\_\_\_\_\_

Are you on a special diet or taking medications/vitamins/supplements? Please list below (use back of page if necessary).

\_\_\_\_\_

Have you had previous experience with professional massage? When, how often and what type?

\_\_\_\_\_

Are there any areas that are *not* to be worked on or treated?

\_\_\_\_\_

What do you hope to receive from regular massage therapy?

\_\_\_\_\_

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

## NOTICE OF HEALTH INFORMATION PRACTICES

### The Center for Family Wellness

Effective April 14<sup>th</sup>, 2003

*The records we create in providing you with care are by law, kept confidential. We are also required to inform you of our policies concerning the use and storage of your personal health information. If you have any comments or questions about our Privacy Notice you may call 256-880-6199.*

## Privacy Policy

The following describes the manner in which we use and disclose your personal health information:

1. We may collect and share appropriate information about you to document the medical necessity of the services we are providing. Examples include diagnosis, prescription, referral and physician or health care provider information.
2. We may share appropriate information about you to bill and collect payment for the health care we provide, including insurance companies and third parties, which includes family members or other financially responsible parties you have informed us of. Examples include insurance coverage and eligibility verification.
3. We may use and disclose information to monitor and operate our business. Examples include satisfaction surveys, health care outcomes and utilization reporting, reports provided to any federal, state or local authority (as required by law), or to remind you of equipment, supplies or service needs.
4. We may release appropriate information about you to family or friends that are helping you with the financial responsibilities incurred while receiving services from us.
5. We may use and disclose information about you to respond to a court or legal authoritative body that legally requests information about you. Examples include providing documents for legal subpoenas or discovery proceedings and our staff testifying about the care we have provided.

The following describes **your** rights to the information we maintain about **you**:

1. You have the right to direct the use of your personal health information.
2. You have the right to terminate or revise your authorizations or consents that pertain to our use of your personal health information, and have those terminations or revisions affect any new service. We are not required to accept your terms. If we do not accept your restrictions, we will honor your specifications, except where prohibited by law. All requests must be in written form.
3. You have the right to request a copy of your personal health information as long as any federal, state or local law does not prohibit it. This request must be in writing. There is a charge for copying, producing and delivering your information.
4. You have the right to request, in writing, a revision to your personal health information. Revision requests will be evaluated on an individual basis and amended, if appropriate. At no time will a revision be made that may erroneously record the personal health information stored by us. Your written request must detail the requested revision and the reasons for the modification. If no explanation is provided, no revision will be made. If we deny your request for amendment, you have the right to file a statement of disagreement.
5. You have the right to request an accounting of non-routine disclosures we have made with your personal health information. You can receive one free accounting service in a twelve-month period. We will charge for any accounting services that exceed one per twelve months. You must agree to this charge before we will provide any accounting services. These requests cover dates of services on or after April 14, 2003.
6. You have the right to file a complaint about our use of your personal health information with the Secretary of the Department of Health and Human Services.

**By signing below, I acknowledge receipt of this Notice of Health Information Practices and that I have been provided a copy of the notice.**

\_\_\_\_\_ Date \_\_\_\_\_

**Patient Signature or Representative for Patient**