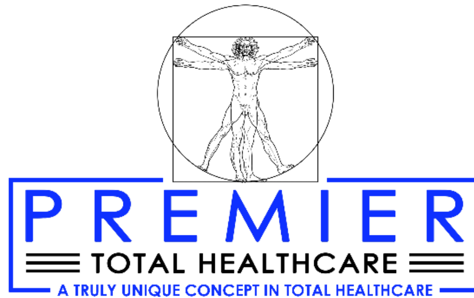

PLEASE FOLLOW THE BELOW INSTRUCTIONS FOR
FILLING OUT AND SUBMITTING YOUR PATIENT INTAKE FORMS

---

1) Make sure this “Premier Intake Forms File” is downloaded to your computer or phone.
2) Mark a ✓ or type the required information into the forms for each section and/or question.
3) Review the forms to ensure that everything has been filled out and completed correctly.
4) Review the forms to ensure all signatures are completed.
5) **Save** this form to your computer or phone.
6) Send the completed **“saved”** form to premier@mypthc.com

Should you have any questions or concerns please call: 954-456-0250

Thank you for your cooperation,

The Premier Total Healthcare Staff

▼ PLEASE PROCEED TO THE FOLLOWING PAGES ▼

♦ ♦ ♦ WELCOME TO PREMIER TOTAL HEALTHCARE ♦ ♦ ♦

Please ☑ Any Services You Are Interested In

WE OFFER FREE CONSULTATIONS ON ANY SERVICE

PHYSICAL MEDICINE

☐ Chiropractic Treatment
☐ Physical Therapy
☐ Traction Therapy
☐ Therapeutic Laser Therapy
☐ Shockwave Therapy
☐ Localized Cryotherapy
☐ Vibration Therapy
☐ Percussion Therapy
☐ Cupping Therapy
☐ Massage Therapy
☐ Personal Training
☐ Pain Injections
☐ PRP Injections
☐ Joint Injections
☐ Trigger Point Injections

SPECIALTY LAB TESTING

☐ Hormone Test
☐ Food Allergy Test
☐ Vitamin Deficiency Test
☐ Hair Mineral Analysis Test
☐ Heavy Metal Test
☐ Blood Test
☐ Covid-19 Test
☐ Other:___________________

ANTI-AGING & WELLNESS

☐ Medical Weight Loss
☐ Exosome Therapy
☐ Hormone Replacement
☐ Low-T Program
☐ Functional Medicine Therapy
☐ Natural Detox Therapy
☐ Nutrition Therapy
☐ Vitamin Therapy
☐ IV Vitamin Therapy
☐ Vitamin Injections
☐ B12 Injections
☐ Lipolean Vitamin Injections
☐ Ionic Detox Foot Bath

MASSAGES

☐ Deep Tissue Massage
☐ Swedish Massage
☐ Sports Massage
☐ Therapeutic Massage
☐ Anti-Cellulite Massage
☐ Post-surgical Massage
☐ Lymphatic Massage
☐ Aromatherapy Massage
☐ Cupping Massage
☐ CBD-Infused Massage
☐ Biofreeze Massage

MEDICAL AESTHETICS

☐ Hair Regeneration
☐ Microneedling with PRP
☐ Dermaplaning
☐ Natural PRP Fillers
☐ Natural PRF Fillers
☐ Botox Cosmetics
☐ Juvéderm Filler
☐ Trichloroacefic (TCA) Peel
☐ Glycolic Acid Peel
☐ Salicylic Acid Peel
☐ Fusion Peel
☐ AHA Vitamin C Peel
☐ Cryotherapy Facial
☐ H2O Facial
☐ Customized Facial
☐ LED Light Therapy

EXAMS & PHYSICALS

☐ Physical Exam
☐ Sports Physical Exam
☐ DOT Exam & Certification
☐ Anti-Aging Wellness Exam
☐ Weight Loss Exam
☐ Hair Regeneration Exam
☐ Pre-Op Clearance Exam

PATIENT INFORMATION

PLEASE FILL OUT THE FORM COMPLETELY

Name: [First] ____________________________ [Last] _______________________________ Sex: ____________

Address: ____ Apt# ______

City: ________________________________ State: __________ Zip: _____________

Age: ____ Date of Birth: ____/____/_______ Marital Status: ________________ Social Security: _____-____-_______

Primary Phone: _______________ Secondary Phone: _________________ Email: ____________________________________

Occupation: __________________ Employment Info: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Other ___________

Emergency Contact: Name: [First] ______________________ [Last] ________________________ Phone: ________________

Relationship to patient: ____________________

How did you hear about us or who referred you? * Please fill out completely

Attorney: _________________ Doctor: _________________ Insurance: __________________ Existing Patient: _________________

Google: _________________ Other: ______________________________

Have you visited our website [www.premiertotalhealthcare.com] before? ☐ Yes ☐ No

If yes, was our website helpful? ☐ Yes ☐ No|If no, please explain ____

☐ I would like to receive appointment reminders and marketing discounts/promotions texts ☐ I would like to opt-out

Reason for visit: *The more descriptive the better we can assist you*

____

____

Additional information we should be aware of: ____

Are you currently pregnant: ☐ Yes ☐ No

If injured, is injury related to: ☐ Auto Accident ☐ Slip & Fall ☐ Work Related ______________ ☐ Other ___________________

Have you been treated for this injury before? ☐ No ☐ Yes | If so, when? _________________________

What treatment was performed or recommended? ____

Who or where was the treatment performed? ____

Is the injury getting progressively worse? ☐ No ☐ Yes | If so, explain: ____

Location of injury: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Back ☐ Leg ☐ Foot ☐ Other __________________

Symptoms related to injury: ☐ Achy ☐ Burning ☐ Numbness ☐ Pins/Needles ☐ Stabbing ☐ Tightness

What is your pain level: ☐ Very Light ☐ Light ☐ Moderate ☐ Severe ☐ Very Severe

Do you take any medications? ☐ No ☐ Yes | If so, please list ____

Medical Insurance Information

Insurance Company Name: _________________________________ Telephone: ________________________

Policy #: __________________ Group #: _________________ Co-pay? ☐ Yes ☐ No | If Yes, Amount: $__________

Signature: Type Name Here ________________ **Date:** _________

MEDICAL HISTORY QUESTIONNAIRE

THIS QUESTIONNAIRE MUST BE FILLED OUT BY ALL PATIENTS

PLEASE MARK A ✓ FOR ANY THAT APPLY

Family History:

Do any of your blood relations have problems with the following?

☐ Asthma ☐ Diabetes ☐ Tuberculosis ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Hearing Loss ☐ Heart Disease

☐ Allergies ☐ Cancer ☐ Thyroid Disease ☐ Bleeding Problems ☐ Problems with Anesthesia ☐ Autoimmune Disease

Past Medical History:

Have you ever been diagnosed with Cancer: ☐ NO ☐ YES If so, please give details: ____

Do you have problems with any of the following?

GENERAL: ☐ NO ☐ Fever ☐ Weight Change ☐ Fatigue

EYES: ☐ NO ☐ Blurred Vision ☐ Visual Loss ☐ Glaucoma ☐ Cataracts ☐ Itchy Eyes ☐ Tearing

EARS: ☐ NO ☐ Vertigo ☐ Dizziness ☐ Ringing Noises ☐ Hearing Loss ☐ Hearing Aid

NOSE: ☐ NO **Discharge:** ☐ Clear ☐ Colored ☐ Thick ☐ Thin ☐ Postnasal Drip ☐ Obstruction

☐ Bleeding ☐ Sneezing

MOUTH: ☐ NO ☐ Lumps ☐ Dental Problems ☐ Tonsillitis ☐ Mouth Sores

THROAT: ☐ NO ☐ Hoarseness ☐ Voice Change ☐ Problem Swallowing ☐ Pain

NECK: ☐ NO ☐ Pain ☐ Lumps ☐ Thyroid Nodules ☐ Swollen Glands

SKIN: ☐ NO ☐ Breast Lumps ☐ Psoriasis ☐ Skin Growth ☐ Rash ☐ Itching

LUNGS: ☐ NO ☐ Coughing Up Blood ☐ Cough ☐ Pneumonia ☐ Positive TB Test ☐ Shortness of Breath

☐ Wheezing ☐ Asthma ☐ COPD ☐ Bronchitis ☐ Emphysema

SLEEP: ☐ NO ☐ Snoring ☐ Apnea ☐ Insomnia ☐ Waking Up Tired ☐ Daytime Tiredness

HEART: ☐ NO ☐ Chest Pain ☐ Mitral Valve Prolapse ☐ Congestive Heart Failure ☐ Heart Valve Disease

☐ Rheumatic Fever ☐ Angina ☐ Murmurs ☐ High Blood Pressure ☐ High Cholesterol

☐ Coronary Artery Disease ☐ Myocardial Infarction

GASTRO: ☐ NO ☐ Heartburn ☐ Reflux Rectal Bleeding ☐ Ulcers ☐ Hepatitis Type ☐ Jaundice ☐ Nausea

☐ Vomiting ☐ Colitis

URINARY: ☐ NO ☐ Frequent Urination ☐ Pain ☐ Discharge ☐ Incontinence ☐ Bloody Urine

MEN: ☐ NO ☐ Prostate Problem ☐ Hernias

WOMEN: ☐ NO ☐ Abnormal Periods ☐ Menopause | Are you pregnant? ☐ Y ☐ N

MUSCLE/JOINTS: ☐ NO ☐ Muscle Pain ☐ Back Pain ☐ Joint Pain ☐ Arthritis ☐ Lupus ☐ Gout

NEUROLOGICAL: ☐ NO ☐ Headaches ☐ Migraines ☐ Imbalance ☐ Alzheimer's disease ☐ Loss of Consciousness

☐ Parkinson's Disease ☐ Head Trauma ☐ Tremors ☐ Fainting ☐ Seizures ☐ TIA's

☐ Strokes ☐ Fainting ☐ Seizures

PSYCHIATRIC: ☐ NO ☐ Nervousness ☐ Anxiety ☐ Depression ☐ Mood Swings

OTHER: ____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU IF ANY CHANGES OCCUR. I HEREBY CONSENT AND GIVE MY PERMISSION TO PREMIER TOTAL HEALTHCARE, THE DOCTOR (AND THE DOCTORS ASSISTANTS) TO ADMINISTER AND PERFORM SUCH PROCEDURES AS THE DOCTOR DEEMS NECESSARY IN THE COURSE OF MY TREATMENT IN THIS OFFICE.

Patient Name: ____________________ **Patient Signature:** Type Name Here ____________ **Date:** __________

AUTHORIZATION FOR EXAMINATION AND TREATMENT

I, _________________________ attest that I am 18 years of age older, if not, am accompanied by a legal guardian over the age of 18. I hereby consent to and authorize examination and treatment by Premier Total Healthcare and their medical staff. In the event of any litigation arising from treatment, I agree to submit the case to arbitration.

Patient Full Name: ___________________________ **Patient Signature:** Type Name Here______________ **Date:** ____________

ASSIGNMENT AND RELEASE OF INSURANCE INFORMATION

I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I authorize the release of my medical records to the insurance company or responsible party for billing purposes. I authorize the insurance company or responsible party to pay directly to Premier Total Healthcare for and inconsideration of services rendered.

The undersigned jointly and severely obligate themselves for the payment of all services rendered by Premier Total Healthcare and their staff. The undersigned hereby acknowledge that I, we are financially responsible for any health insurance deductible, co-insurance, RNFA fee, or failure for any reason of any insurance carrier to pay Premier Total Healthcare's charges, which include medical charges together with all court costs, private process fees, collection costs and attorney's fees. I certify that the information I have reported with regards to my insurance coverage is accurate and up to date.

With my signature below, I hereby authorize my insurance carrier to remit all payments to Premier Total Healthcare

I hereby agree to notify the office 24 hours in advance of any cancellation or rescheduling of my appointment. I understand that a $75 cancellation fee may be imposed.

Patient Full Name: ___________________________ **Patient Signature:** Type Name Here______________ **Date:** ____________

NOTICE OF PRIVACY PRACTICES

At Premier Total Healthcare, your privacy is a very important part of our mission and confidentiality is a very big factor in your experience. Premier Total Healthcare and its staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003. As of April 14th, 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI). Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment, or health care operations
- How you may request copies of your healthcare information
- How you may verify the accuracy of this information
- How you may request an accounting of certain external disclosures of your PHI

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email, mail, or phone. Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by the office of Premier Total Healthcare and I fully understand and accept the terms of this consent."

Patient Full Name: ___________________________ **Patient Signature:** Type Name Here______________ **Date:** ____________

DECLARATION OF TRUTH AND HONORABLE INTENT

All Patients MUST Review and Sign this Page

1. I hereby give my consent to Premier Total Healthcare and authorize them to perform a consultation, service, physical examination and/or routine procedure on me.
2. I hereby verify that my visit today is ☐ related, ☐ is not related to an automobile accident or work related incident.

I hereby declare that all the information provided to Premier Total Healthcare about my personal and medical history is truthful and accurate. No attempt is being made to mislead or magnify my condition in any way for any reason. I am here of my own volition and have not been sent by another for any reason. I certify and swear that I do not represent, work for, nor have any affiliation with any government agency, corporation, or other organization for purposes of trickery or entrapment. I understand that Premier Total Healthcare must be able to rely upon the information I provide to properly consult, provide a service, and/or diagnose my condition, and develop an effective treatment plan if deemed necessary.

Patient Name: ____________________________ **Patient Signature:** Type Name Here____________________________ **Date:** _________

DISCLOSURE & CONSENT
FOR CHIROPRACTIC ADJUSTMENTS AND CARE

If you are receiving Chiropractic Care, please review and sign this document

***If you are NOT receiving Chiropractic Care, you do not need to fill out or sign this document**

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or patient named below, for whom I am legally responsible) by the doctor of Premier Total Healthcare or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Premier Total Healthcare.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read the above and consent. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

Patient Name: ______________________________ **Signature:** Type Name Here______________ **Date:** _________

Or

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically legally incapacitated

Patient Representative Name: ______________________________

Relationship to Patient: ___________________________

Patient Representative Signature: Type Name Here____________ **Date:** ________

AUTOMOBILE ACCIDENT QUESTIONNAIRE

THIS QUESTIONNAIRE MUST BE FILLED OUT BY ALL PATIENTS WHO HAVE BEEN IN AN ACCIDENT

If you have NOT been in an accident, you do not have to fill out this form

PLEASE MARK A ✓ FOR ANY THAT APPLY

Please answer all questions below. If you do not know the answer, you can skip that question.

Your vehicle type:

☐ Car ☐ SUV ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Large Truck ☐ Bus ☐ Other _______________

Your position in vehicle:

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger ☐ Other _______________

What was your vehicle doing the time of the accident:

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light ☐ Making a right turn ☐ Making a left turn

☐ Parking ☐ Proceeding along ☐ Slowing down ☐ Accelerating ☐ Other ______________________________

Time/Speed/Damage:

Time of accident __________|Your vehicles speed _______ mph|Their vehicles speed _______ mph

Damage to your vehicle ☐ Mild ☐ Moderate ☐ Totaled

Details of accident:

Visibility at time of accident ☐ Poor ☐ Fair ☐ Good

Who hit who/what ☐ Other vehicle hit you ☐ You hit other vehicle ☐ You hit object _______________________

Road conditions:

☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact:

☐ Head-on ☐ Rear-end ☐ Left front ☐ Right front ☐ Left rear ☐ Right rear

Body position:

Did you see the accident coming ☐ Yes ☐ No

Did you brace for impact ☐ Yes ☐ No

Did you have a seat belt on ☐ Yes ☐ No

Did you have a shoulder harness on ☐ Yes ☐ No

Vehicle details:

Does your vehicle have headrests ☐ Yes ☐ No

What position was headrest at impact ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What position was your head at impact ☐ Facing straight forward ☐ Turned to right ☐ Turned to left

Driver side airbag deploy ☐ Yes ☐ No|Passenger side airbag deploy ☐ Yes ☐ No|Side airbag deploy ☐ Yes ☐ No

During the accident:

Did your body strike the inside of the vehicle ☐ Yes ☐ No|If yes, describe _____________________________________

Did you lose consciousness during the injury ☐ Yes ☐ No|If yes, describe _____________________________________

Your vehicles estimated damage $______________

Damage to their vehicle ☐ Mild ☐ Moderate ☐ Totaled|Did the police show up to the scene ☐ Yes ☐ No

Was an accident report filled out ☐ Yes ☐ No

CONTINUE TO NEXT PAGE…

After the accident:

Check off your symptoms right after the accident, and a few days following

☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Low back pain ☐ Cold hands ☐ Neck pain ☐ Nausea ☐ Cold feet

☐ Neck stiffness ☐ Confusion ☐ Nervousness ☐ Diarrhea ☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression

☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious ☐ Loss of smell ☐ Irritability ☐ Constipation

☐ Chest pain ☐ Pain behind ears ☐ Shortness of breath ☐ Sleeping problems ☐ Other ______________________________

Emergency room:

Where did you go after the accident ☐ Home ☐ Work ☐ Private doctor ☐ Hospital/Emergency Room

How did you get there ☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police

Were X-rays done ☐ Yes ☐ No | Body parts X-rayed ___________________ X-rays revealed _______________________________

Was lab work done ☐ Yes ☐ No | What lab work was done ____

Treatments ☐ Cervical collar ☐ Ice ☐ Other ______________ Medications ____________________________________

Follow-up instructions ____

Treatment history:

Fill in any other doctor(s) seen prior to your first visit to this office

Frist Doctor Name _______________________ Date of visit __________ Specialty ________________ X-rays done ☐ Yes ☐ No

Types of treatments received ____

Did treatments benefit you ☐ Yes ☐ No | Last visit date _________

Second Doctor Name _______________________ Date of visit __________ Specialty ________________ X-rays done ☐ Yes ☐ No

Types of treatments received ____

Did treatments benefit you ☐ Yes ☐ No | Last visit date _________

Third Doctor Name _______________________ Date of visit __________ Specialty ________________ X-rays done ☐ Yes ☐ No

Types of treatments received ____

Did treatments benefit you ☐ Yes ☐ No | Last visit date _________

Additional accident information:

____

____

Patient Full Name ______________________________ **Patient Signature** Type Name Here ____________ **Date** _________

HIPAA Notice of Privacy Practices

ALL PATIENTS MUST REVIEW AND SIGN THIS FORM

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, 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

HIPAA

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 diagnose 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 hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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. For example, we may disclose your protected health information to medical school students that see patients at our office. 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. If we use or disclose your protected health information for fundraising activities, we will provide you with the choice to opt out of those activities. You may also choose to opt back in.

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 proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other 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.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

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

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) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. 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 proceeding, 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 except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

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 disclosures, paper or electronic, 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 the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to 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 of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER: Dr. Kevin McGrath Phone: 954-456-0250

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

______________________	Type Name Here ______________________	______________
Print Name	**Signature**	**Date**