CONFIDENTIAL PATIENT CASE HISTORY

Last Name: ______________________________________ First Name: _______________________________

Address: ______________________________________ City ___________________State _____ Zip________

Home Phone: _________________________________ Cell Phone: ___________________________________

Occupation: _____________________________________ Work Phone: _________________________________

Sex: M F Birthdate: __________________ Age: _________ Marital Status: M S W D

Social Security #: ____

E-Mail: ____

Emergency Contact & Telephone: ____

How did you hear about Capital Sports Injury Center?

□ Personal Referral – Name:	□ Graston Techniques Website	□ Running Club
□ Doctor Referral – Name:	□ Web Search	□ Cycling Club
□ Active Release Techniques Website	□ Our Sign	□ Other:_____________

INFORMED CONSENT

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 and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

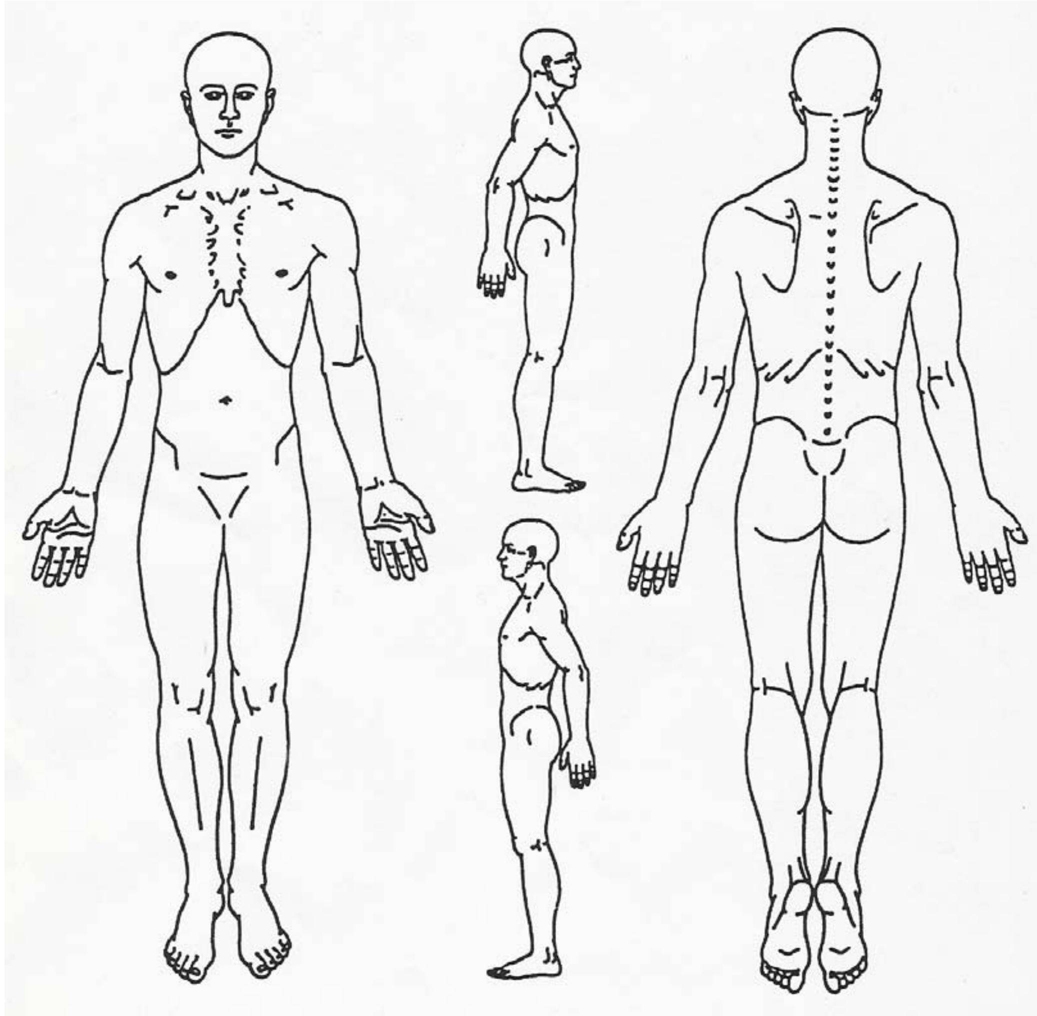
Patient's Signature:____ Date: ____________

Guardian or Spouse's Signature:____ Date: ____________

PAIN DRAWING – ONE COMPLAINT PER DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. Please complete one drawing per area of pain, e.g. If you have shoulder, neck, and knee pain, complete three drawings.

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**T =**	**Throb**
DP=	**Deep**	**SH=**	**Shallow**	**C =**	**Cold**	**O =**	**Other**



Please circle how you would rate your pain RIGHT NOW: 0 means no pain, 10 means agony

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

Please circle your TYPICAL or AVERAGE PAIN: 0 means no pain, 10 means agony

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

NAME: (please print)____

SIGNATURE:______________________________ DATE:__________________

Capital Sports Injury Center, Steven M. Horwitz, D.C. 301-622-9000 www.DCSportsInjury.com

Silver Spring Georgetown

COMPLAINT

(One area per form, e.g. If you have shoulder, neck, and knee pain, please complete three forms)

What is your major/presenting complaint? (Please provide an exact description)

____

____

What is the location of the complaint? ____

When did the pain begin (be as specific as possible)? ____

Is the pain constant (all day long, no relief)? □ Yes □ No

Does the pain come and go? □ Yes □ No   If yes, how frequent is it (e.g., times per day or times per week)?

____

Was there a precipitating event? □ Yes □ No   If yes, what (e.g., lifting, bending, etc.)?

____

What makes the condition worse? □ Bending □Lifting □Twisting □Sitting □Standing □Pushing □Pulling □Other

____

How does it interfere with or restrict your daily living (e.g., unable to lift child, unable to put on coat, etc.)?

____

What makes the condition better (e.g., ice, heat, rest)?

____

Do you have a history of similar conditions in the past? □ Yes □ No   If yes, when? ______________________

Is the condition getting: □Worse □Same □Better

Is there a particular time of day when your condition is worse? □Morning □Afternoon □Evening □Night □Activity

Have you had other examination and/or treatment of this problem? □ Yes □ No

Have you had any associated symptoms like (circle):

Unexplained weight loss	Infection	Dizziness
Loss of bladder or bowel control	Fever or chills	Ringing in the ears
Pain that awakens you in the middle of the night	Persistent swelling	Visual changes
Complete loss of feeling	Rash	Difficulty breathing
Complete loss of strength	Debilitating Headache	Shortness of breath
Coss of coordination	Nausea	Chest pain
Trouble balancing	Vomiting	Difficulty swallowing

Women only: Are you pregnant? □ Yes □ No

REVIEW OF SYSTEMS

PAST MEDICAL HISTORY

Hospitalizations/Fractures/Serious Illnesses

Date	For what?

Surgeries

Date	What type of surgery?

Have you EVER HAD (circle):

Tumors – benign or malignant   Infection   Concussion   Cancer   Broken Bone (fracture)   Severe Fatigue
Eyes: Recent prescription change, vision loss, eye disease
Ear, Nose, Mouth, Throat: Hearing loss, Sinusitis, Polyps, Jaw problems, Thyroid problems
Cardiovascular: Chest pain, calf pain, foot/ankle/leg swelling
Respiratory: Shortness of breath
Gastrointestinal: Heartburn, constipation, diarrhea
Urinary: Incontinence, pain on urination or bowel movement
Skin: Discoloration, skin cancers

Current Health Problems □ None

____

____

Current Medications

Name:	For?	Name:	For?
Name:	For?	Name:	For?
Name:	For?	Name:	For?

FAMILY MEDICAL HISTORY

Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders? Please list family member next to disorder: M=Mother, F=Father, B=Brother, S=Sister, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGF=Paternal Grandfather, PGM= Paternal Grandmother

High blood pressure___________________________   Heart Disease___________________________
Cancer___________________________   Diabetes___________________________
Thyroid___________________________   Kidney___________________________
Arthritis___________________________   Tuberculosis___________________________
Stroke___________________________   Lung disease___________________________

SOCIAL HISTORY

Do you drink alcohol? □ Yes □ No,   If Yes, how many drinks per week? _____
Do you smoke? □ Yes □ No,   If Yes, how many packs per day? _____   For how many years? _____
Do you primarily □ Stand □ Sit at work?
Do you exercise? □ Yes □ No,   If Yes, what type of exercise? ___________________________
How frequently? ___________________________

ACCIDENT HISTORY

Date of accident_______________ **Time of Accident**_____________(AM/PM)

Were you: □ Driver □ Passenger (Front) □ Passenger -Rear Driver's Side □ Passenger – Rear Passenger Side

□ Pedestrian **Vehicle Driven By:** _______________________________ **Number of people in vehicle with you:** ______________

Your vehicle: □ Auto □ Truck □ Van □ Motorcycle □ Motor Home □ Bicycle **Year/Make/Model**_______________________

Your estimated speed at the moment of the crash: □ Stopped □ Slowing down □ Speeding Up □ Breaking

What was the approximate damage done to the car you were in? □ Minor □ Moderate □ Severe **Was it drivable?** □ Yes □ No

Other vehicle: □ Auto □ Truck □ Van □ Motorcycle □ Motor Home □ Bicycle **Year/Make/Model**_______________________

Visibility at time of accident: □ Poor □ Fair □ Good **Time of Day:** □ Daylight □ Dawn □ Dust □ Dark

Road conditions at time of accident: □ Dry □ Wet □ Rainy □ Snow □ Ice

How accident occurred: □ Struck by another vehicle □ Struck another vehicle □ Struck stationary object □ Other _____________

Where was your vehicle hit (circle): □ Front □ Rear □ Rt Side □ Lt Side □ Rt Front □ Lt Front □ Rt Rear □ Lt Rear

Other vehicle contact (circle): □ Front □ Rear □ Rt Side □ Lt Side □ Rt Front □ Lt Front □ Rt Rear □ Lt Rear

Did you see the accident coming? □Yes □ No **Were you pre-warned that the accident was about to happen?** □Yes □ No

Did you brace for impact? □ Yes □ No

Were you wearing a shoulder harness? □ Yes □ No □ Don't Know **Were you wearing seatbelts?** □ Yes □ No □ Don't Know

Does the vehicle have headrests? □ Yes □ No □ Don't Know

If yes, what was the position of those headrests compared to your head before the accident? □ Top of headrest even with bottom of head □ Top of headrest even with top of head □ Top of headrest even with middle of neck.

Was the headrest position altered by the crash? □ Yes □ No □ Don't Know

What was your head position at the time of impact?
Head turned: □ Right □ Left □ Looking back □ Straight ahead
Body rotated: □ Right □ Left

Were your hands on the wheel? □ One hand on wheel □ Two hands on wheel

Was the seat broken? □ Yes □ No □ Don't Know **Was the seatback adjustment altered by the crash?** □ Yes □ No □ Don't Know

Did the airbag deploy? □ Yes □ No **If yes, were you struck?** □ Yes □ No **Location of strike:** ______________________________

What occurred at the moment of impact? (Circle as many as apply)

□ Tensed Body for impact □ Neck whipped forward and back □ Spine torqued and twisted
□ Thrown over seat □ Thrown from vehicle □ Pinned in vehicle
□ Thrown from side to side □ Cut and bruised □ Other__________________________________

Did you strike your: (Circle as many as apply)

A)Head	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Head Rest	Unknown object
B) Shoulder	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
C) Arm	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
D) Elbow	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
E) Wrist	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
F) Hip	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
G) Knee	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
H) Ankle	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object

Were you rendered unconscious? □Yes □ No □ Don't Know

Were you able to move all of your body parts? □ Yes □ No If no, explain ____

Were you able to get out of the car unaided? □ Yes □ No If no, explain ____

Did you bleed or get cuts and bruises? □ Yes □ No Location? ____

Were there any flying objects in the car? _____________ Were you hit? ___________ Where? ___________________

In your own words please describe the accident:____

____

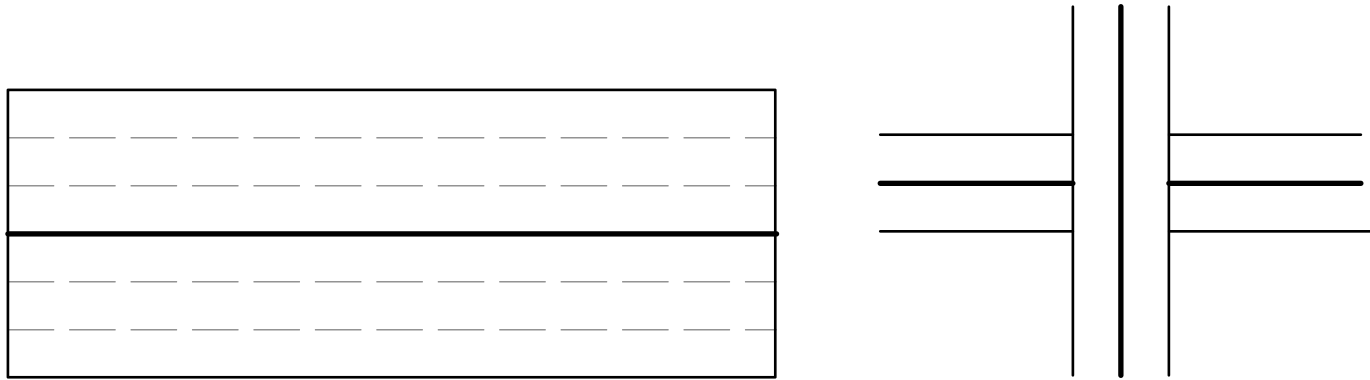
____

____

____

____

INDICATE ON APPROPRIATE DIAGRAM HOW THE ACCIDENT HAPPENED:



Did the police come to the scene? □ Yes □ No **If yes, was a report made?** □ Yes □ No

Please describe how you felt:

A. DURING the accident:______________________________

B. IMMEDIATELY AFTER the accident**:** ______________________________

C. LATER THAT DAY: ______________________________

D. THE NEXT DAY: ______________________________

Did you receive medical attention at the scene of the accident? □ Yes □ No

If yes what was done? ______________________________

Were you taken by ambulance to the hospital? □Yes □ No If yes, where?______________________________

What was done?______________________________

What was the diagnosis given?______________________________

Please list prescribed medications: ______________________________

Where did you go immediately after the accident? □ Hospital/Doctor □ Resumed activities □ Home □ This office

Hospital or Doctors office: Where? ____________________Were you examined? □ Yes □ No

Were you x-rayed? □ Yes □ No If yes, what area? ____________ What treatment was given? ______________

Please list medications: ______________________________

Did you return to the doctor's office? □ Yes □ No If yes, please list dates: ____________________

Second Doctor/Clinic:______________________________**Date of first visit:**______________

Were you examined? □ Yes □ No Were X-rays taken? □ Yes □ No

Were you given treatment? □ Yes □ No If yes, explain______________________________

Please list medications: ______________________________

Did you return to the doctor's office? □ Yes □ No If yes, please list dates: ____________________

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headache	__Dizziness	__Light bothers eyes	__Cold sweats
__Neck pain	__Head heavy	__Loss of memory	__Feet cold
__Neck stiffness	__Pins/Needles in arms	__Ears ring	__Hands cold
__Sleeping problems	__Pins/Needles in legs	__Face Flush	__Stomach upset
__Numbness in Fingers	__Buzzing in ears	__Constipation	__Loss of taste
__Mid back pain	__Nervousness	__Loss of balance	__Diarrhea
__Low back pain	__Numbness in toes	__Tension	__Shortness of breath
__Fainting	__Fever	__Loss of smell	__Vomit
__Irritability	__Fatigue	__Chest pain	__Depression

Symptoms other than above: ______________________________

PATIENT-SPECIFIC ACTIVITY SCORING SCHEME (circle one number): Scale of 0 - 10, 0 = unable to perform the activity and 10 = able to perform activity at the same level as before injury or problem.

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Excruciating pain

FOR EACH OF THE FOLLOWING ACTIVITIES WRITE NUMBER USING ABOVE SCALE:

___Coughing or sneezing	___Lying on side	___Gripping
___Getting in/out of car	___Bending forward	___Pushing
___Bending to brush teeth	___Climbing stairs	___Pulling
___Turning over in bed	___Kneeling	___Reaching
___Walking short distances	___Balancing	___Sexual activity
___Standing for more than 1 hour	___Dressing self	___Stooping
___Lying on back	___Sleeping	___Lying on stomach
___Sitting at table	___Other___________________________	

Have you lost any time from work as a result of this accident? □ Yes □ No If yes, please complete below:

a. Last day worked: ___________________________

b. Type of employment: ________________________

c. Are you being compensated for time from lost work? □ Yes □ No

Did you have any physical complaints before the accident? □ Yes □ No If yes please describe:

____

____

____

Have you ever been involved in an accident before? □ Yes □ No If yes, describe and indicate date of each one:

____

____

INSURANCE INFORMATION

Name of YOUR Auto Insurance Company: ____

Claim #: ____

Insurance Adjustor's Name: ____

Insurance Adjustor's Phone #: ____

ATTORNEY INFORMATION

Name of your attorney: ____

Phone #: ____

CAPITAL SPORTS INJURY CENTER, Steven M. Horwitz, D.C.

OFFICE POLICY

Hello and welcome to Capital Sports Injury Center. It is our goal to provide you with the best chiropractic and rehabilitative care available in the area. This includes a clear definition of our office policies stated below. Please take the time to read and sign where appropriate. If you have any questions please do not hesitate to ask. We look forward to working together to help you **regain and maintain your health!**

APPOINTMENT POLICY

Whether your appointment is with the doctor or the functional exercise specialist, your appointment time is reserved for only you. Our office DOES NOT double book appointments**. 24 hours notice is required should you need to cancel an appointment.** You will be charged the full fee of your office visit should you fail to give 24 hours notice. It is important that you be on time for your appointment. If you are late, we will make every effort to see you, but it may not always be possible. Your will still be responsible for your appointment fee if you are late.

Signature__________________________________ Date_________________

PERSONAL INJURY (Auto Accidents, Slips and Falls)

1. I understand that I am responsible for the entire payment of any and all services rendered.

2. I understand that all bills are to be paid at 100% of the fee charged.

3. I understand that the insured must request an **APPLICATION FOR BENEFITS** from the insured's PIP carrier so that the accident can be documented and that the insurance coverage can be verified. I understand that if the Application for Benefits is not returned to the insurance carrier, **NONE OF THE BILLS WILL BE PAID BY THE INSURANCE CARRIER.**

4. As a courtesy to the patient, Capital Sports Injury Center will submit the bills and notes to the insurance carrier. I authorize payment of all benefits to the undersigned chiropractor for all services rendered. I authorize the release of any medical or other information necessary to process all claims.

5. A $30 reprocessing fee will be charged to your account should any personal check fail to clear.

_________________________________ _____________________________________ ________

Print Name Signature Date

Steven M. Horwitz, D.C.

LIEN ASSIGNMENT

I ___________(patient name) residing at __________________(address) hereby enter into the following agreement with (medical provider), hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay <u>all</u> remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of benefits.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to ____________(medical provider).

Dated: _______________ Patient's Signature: ______________________________________

Dated: _______________ Attorney's signature: _____________________________________

Please date, sign and fax (301-622-1961) back to our office. Thank you.

Steven M. Horwitz, D.C.

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the ___________________________________ Insurance Company to pay by check for the medical/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the professional services rendered by Steven M. Horwitz, D.C. This check must be made out and mailed directly to:

Steven M. Horwitz, D.C.
12200 Tech Road
Suite 104
Silver Spring, MD 20904

This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay in a current manner, any balance of said professional service charges over and above the insurance payment.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved in the case.

Dated: ____________

Patient's signature: ____

Policy Holder's signature: _____________________________________

Steven M. Horwitz, D.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/ X-RAYS

To____

Doctor or Hospital

____

Address

I hereby authorize and request you to release the medical records of:

____

Patient

To: Steven M. Horwitz, D.C.
12200 Tech Road, Suite 104
Silver Spring, MD 20904
301-622-9000 301-6221961 (fax)

Date_____________________________ Signed_________________________

Witness___________________________ Relationship____________________

IMPORTANT INFORMATION – PLEASE READ

On your first visit, the doctor will take a history and perform a thorough examination. Please think about your condition and be able to answer the following questions:

- When did your pain begin? Was the onset sudden or gradual?
- Where is the specific site of your pain?
- If you have more than one area of pain, which is the most painful and most important one to treat?
- What activities or movements increase your pain?
- What, if anything, diminishes your pain?
- What movements or activities are you unable to perform due to your condition?

Please bring:

- Shorts and a sleeveless T-shirt
- Any prior X-rays, MRIs, CAT Scans (films and reports), blood work reports and any other important medical records

What can we do for you…?

We want your experience at our clinic to be a good one. What would you like to achieve by coming to our clinic?

____

____

FREQUENTLY ASKED QUESTIONS ABOUT CHIROPRACTIC CARE

What education does a chiropractor receive?
A four-year undergraduate degree is required to be accepted to chiropractic school. Chiropractic school is a four-year program consisting of 4800 hours of classroom, laboratory, and clinical study, including anatomy, physiology, chiropractic technique, radiology, biochemistry, toxicology, biomechanics, nutrition, diagnosis and physical examination, and a one-year internship. Upon completion, a Doctor of Chiropractic (D.C.) degree is granted.

Can a chiropractor really make a diagnosis?
YES! One case I will never forget illustrates the importance of proper diagnosis in chiropractic practice. A 45-year-old woman came in complaining of severe lower back pain. As I was examining her, I noticed that the end of each finger was deformed, like fluid had accumulated in the pad of each finger. The woman was a smoker and had been examined three months prior, but the changes to her fingers were never noticed by the other doctors. Lumbar (low back) X-rays showed destruction of a portion of two vertebrae and chest films showed a large metastasis (tumor) to the lung. She was immediately referred to an oncologist.

Do chiropractors treat muscles as well as bones?
YES! When muscles (tendons and ligaments also) are "pulled" or "strained" it means they have torn. Think of each muscle fiber as a single strand of rope. Did one strand of rope tear or did the entire rope tear? When this tear heals, it forms a tight knot called an adhesion (like the lumps when you knead bread dough). To break up this knot, we use several techniques: Active Release Technique® and Graston Technique®, Kinesio® Tape, Cold Laser, and Corrective Exercise. Medications like ibuprofen (Advil, Motrin, Nuprin), naproxen (Aleve), Celebrex or Vioxx can help temporarily with the initial inflammation and pain, but they prevent proper healing of the muscle tissue and have significant side effects, especially gastro-intestinal bleeding.

How long do I have to come for treatment?
No patient is treated longer than they want or need. Our motto is "We don't keep you coming, we get you going!" Getting well and STAYING well is the goal. Most of our patients realize the benefits of what we call performance care.

NOTICE OF PRIVACY PRACTICE SUMMARY

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

Capital Sports Injury Center, Steven M. Horwitz, D.C., a Maryland Chiropractic Practice (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information ("PHI"), in other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications:** To receive correspondence of confidential information by alternate means or location. To do this, please make a request in writing.
- **Access:** To inspect or receive copies of your PHI. To do this, please submit a request in writing.
- **Amendments:** To request changes be made to your PHI. To do this, please submit a request in writing.
- **Accounting:** To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. . To do this, please submit a request in writing.
- **This notice:** To get updates or reissue of this notice, at your request.
- **Complaints:** To complain to our office or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Steven M. Horwitz, D.C., at 12200 Tech Road, Suite 104, Silver Spring, MD 20904 or via email at **painfree123@gmail.com.**

Effective Date: This Notice is in effect as of April 14, 2003. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

____________________	____________________	__________
Print Patient Name	**Sign Patient Name**	**Date**

Steven M. Horwitz, D.C.

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Capital Sports Injury Center and all assistants to administer any and all treatment as deemed necessary to my

____________________________ ______________________________________.
(Indicate Relationship to Child) (Name of Child)

Dated at ____
City State

This _________________ day of ____
Month

Signed ____
(Parent or Guardian)

Witnessed ____