SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH CHIROPRACTIC NEW PATIENT INTAKE

Today's Date:_____

Name:_____ Date of Birth _____ Age_____

Address _____ City_____ Zip _____
Phone ( )_____ Email _____

Occupation _____ Employer _____
Address _____ Work Phone _____

Marital Status: M S W D Children Y / N #_____
Name of Spouse _____ Occupation _____
Spouse's Employer_____ Work Phone _____

Emergency Contact _____ Contact Phone _____
Relationship of emergency contact (Parent/ Other Relative/ Friend) _____

Referred By (circle): Internet / Provider Manual / Other Physician / Friend or Relative
Name _____

Date of last physical examination _____
Reason for visit today? _____
Is your visit the result of an auto or work injury? Y / N If yes, which _____
_____

Are you currently taking any medications (Prescribed or "Over the Counter")? _____
_____

Additional Information _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment / Insurance Information
Name of person responsible for payment _____
Are you insured? Y / N Company _____
Would you like us to bill your insurance Y / N

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Simple Health Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to them will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. With my signature I hereby state that all of the above information was truthful and accurate to the best of my knowledge.

Patient's Signature: _____ Date _____

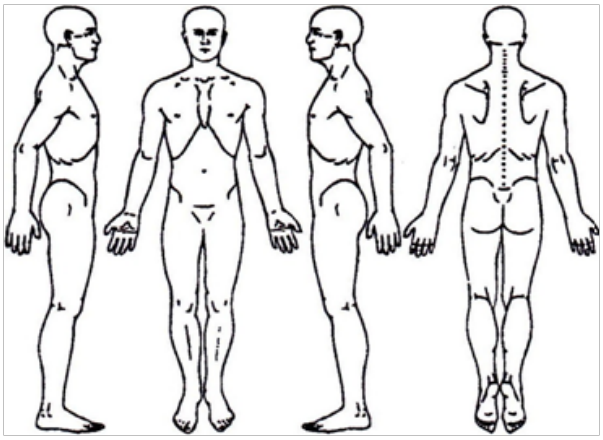
Guardian's Signature Authorizing Care: _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

Name: _____

On the diagrams, mark where you currently have pain or other symptoms. Include symptoms of pain, numbness, tingling, etc..



Please check all of the following that apply to you: ☐ None Apply

Yes	No	Condition	Yes	No	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births_____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Corticosteroid Use (Steroid inhaler)	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date)	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use: #_____day/wk
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use:#_____day/wk
☐	☐	Aortic Aneurysm Cancer/Tumor	☐	☐	Surgeries/Medications: _____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/ Stroke

Current Work Activities: ☐ Sit more than stand ☐ Stand more than sit ☐ Sit/stand equally ☐ Walking

Previous Auto Injuries: ☐ No ☐ Yes, Describe_____

Previous Work Injuries: ☐ No ☐ Yes, Describe_____

Allergies:_____

Exercise Habits: ☐ None ☐ Regular Program ☐ Semi-regular program (Describe) _____

_____

I certify that the above information is complete and accurate. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature: _____ Date: _____

SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

1. Date Problem(s) Began: _____
2. How did your current problem(s) begin:

_____

_____

_____

3. Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

_____

_____

4. Have you had spine x-rays, MRI or CT Scan? ☐ Yes ☐ No
   Date(s) Taken:_____ What areas were taken? _____

Please complete the following questions for each problem that you are having

Problem #1 _____

Problem 1 (how you feel today): Please Mark an "I" at your current level of symptoms

No Pain or Discomfort |——————————————————| Severe Pain or Discomfort

Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present? _____

_____

Problem #2 _____

Problem 2 (how you feel today): Please Mark an "I" at your current level of symptoms

No Pain or Discomfort |——————————————————| Severe Pain or Discomfort

Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present? _____

_____

Problem #3 _____

Problem 3 (how you feel today): Please Mark an "I" at your current level of symptoms

No Pain or Discomfort |——————————————————| Severe Pain or Discomfort

Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present? _____

_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

NAME:_____ DATE OF BIRTH:_____
LAST FIRST MIDDLE

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Doctor:_____

Address of Doctor:_____

PhoneNumber:_____

FaxNumber:_____

Recipient

Name of Provider: Dr. Mireya Hernandez

Address of Provider: Simple Health Chiropractic
3939 Atlantic Ave., Suite 203 Long Beach, CA. 90807
Phone Number: 562-424-5505

Fax Number: 562-424-1055

INFORMATION TO BE DISCLOSED: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.

☐ All of my health information described above except for the following: _____
_____

☐ Only the following records or types of health information: (insert dates of treatment, types of treatment or other designation) _____
_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

TERM: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

REDISCLOSURE: I understand that once my health care provider discloses my health information to the recipient identified, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health information.

REFUSAL TO SIGN/RIGHT TO REVOKE: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

REVOCATION: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on the Authorization before it received my written note of revocation.

QUESTIONS: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this authorization from my health care provider.

PHOTOCOPY: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Patient's Name (Please Print) _____

Patient's Signature: _____ Date:_____

IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW:

Signature of Personal Representative: _____

Legal Relationship: _____ Date:_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME:_____ DATE OF BIRTH:_____
LAST FIRST MIDDLE

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Provider: Dr. Mireya Hernandez

Address of Provider: Simple Health Chiropractic
3939 Atlantic Ave., Suite 203 Long Beach, CA. 90807
Phone Number: 562-424-5505

Fax Number: 562-424-1055

Recipient (Primary Care Doctor or Other Specialist)

Name of Doctor:_____

Address of Doctor:_____

PhoneNumber:_____

FaxNumber:_____

INFORMATION TO BE DISCLOSED: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.

☐ All of my health information described above except for the following: _____
_____

☐ Only the following records or types of health information: (insert dates of treatment, types of treatment or other designation) _____
_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

TERM: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

REDISCLOSURE: I understand that once my health care provider discloses my health information to the recipient identified, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health information.

REFUSAL TO SIGN/RIGHT TO REVOKE: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

REVOCATION: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on the Authorization before it received my written note of revocation.

QUESTIONS: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this authorization from my health care provider.

PHOTOCOPY: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Patient's Name (Please Print) _____

Patient's Signature: _____ Date:_____

IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW:

Signature of Personal Representative: _____

Legal Relationship: _____ Date:_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH CREDIT CARD ON FILE AUTHORIZATION

Information to be completed by the card holder:

Card holder Name: _____

Card Number: _____

Card Type: _____Expiration Date: _____

Security Code: _____ (3 digit code on back or 4 digit code in front for AMEX)

Billing Zip Code: _____

Email: _____

Per the Cancellation/ No-show Policy which I have read and signed

I, _____ authorize Simple Health Chiropractic to charge the above credit card in the amount of $25 for any late cancellation or no-show appointments. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Card holder Signature: _____ Date: _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH 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, 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 work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other 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 and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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) f)or which I seek treatment.

Patient's Signature: _____ Date: _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH LATE CANCELLATION AND MISSED APPOINTMENT POLICY

At Simple Health, we understand that unanticipated events happen occasionally in life. While truly sympathetic, the clinic cannot absorb the financial responsibility of last minute cancellations. In our desire to be effective and fair to all clients, the following policies are in effect.

All appointments require a 24-hour notice for cancellation. This allows the opportunity for someone else to schedule an appointment. Any late cancellations or no-shows within less than 24 hours of appointment time are subject to a fee of **$25**.

Massage Appointments:

Since all massage services are by appointment only, a major credit card on file is required to hold your appointment. Your credit card will not be charged until services are rendered, unless you fail to cancel within 24-hours and/or no-show to your appointment. If you are unable to give us 24-hours notice, your credit card on file will be charged a fee of $25. **You have the option to pre-pay for your massage if you do not want to have a credit card on file.**

Pre-Paid Package Appointments:

If you have a Pre-Paid package for any service and you are unable to give us 24-hours advance notice to cancel your appointment, you will be billed a fee of $25. If you do not have a credit card on file, you have 3 business days to pay the cancellation fee, otherwise a session will be deducted from your package equal to the missed appointment time.

We have tried to make this information clear and understandable. Should you have any additional questions, please feel free to discuss this with our reception.

☐ I have read the following information above and have been informed of the policies and procedures regarding cancellations.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have the right to refuse to sign this acknowledgment.

I,_____, have received a copy of the Notice of Privacy Practices
(PLEASE PRINT NAME)
for the above referenced practice.

Signature:_____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgment of Receipt of our Notice of Privacy Practices from the above individual, but acknowledgment could not be obtained because:

- ☐ The individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other reason, as follows:_____
  _____
  _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

PATIENT RIGHTS PRIVACY NOTIFICATION

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the purposes listed in this document. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Compliance Officer.

Right to a Paper Copy: You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION
Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our business associates, such as our computer service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers who participate in your insurance plan.

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification / communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing: We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

Required by law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health oversight activities: We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial / administrative proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

Law enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners: We may, and are often required by law, to disclose health information to coroners in connection with their investigations of deaths.

Public safety: We may, and are sometimes required by law, to disclose your health information to, appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Workers' Compensation: We may disclose your health information as necessary to comply with workers compensation laws. For example, to the extent your care is covered by workers compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers compensation insurer.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information / record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

YOUR HEALTH INFORMATION RIGHTS

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
3939 Atlantic Ave., STE 203
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

Right to Amend or Supplement: You have aright to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health Information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2(payment), 3(health care operations), 6(notification and communication with family) and 16(specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.