HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

CHILD HEALTH HISTORY

Name of Patient		Date	
Gender	Male ☐ Female ☐	Date of Birth / /	Age
Address			
Address		Phone Number	
Parent(s) Name			
Education Level Attained			Age
Parent(s) Name			
Education Level Attained			Age
Legal Guardian			
Person completing form			
Email			

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.
Please check any box that applies:

Has anyone in the family had:	***Siblings***	***Parents***	***Extended Family***
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

Parents are: Married ☐	Living together ☐	Divorced ☐	Separated ☐ Widowed ☐

BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure, etc? _____

Did you receive any vaccinations while pregnant? ___Yes ___No

Was any dental work done while pregnant? ___Yes ___No

If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of a spouse's job, separation, etc?

_____

Please check what best describes your labor and birth of your child?

___Normal (no interventions)
___Mother was sick
___Complications during birth
___Problems with the umbilical cord
___Rh Factor problems
___Long/difficult labor
___Epidural given
___Facial/breech/brow presentation
___Caesarian section
___Forceps or suction used
___Induced

Did your child have any of the following problems at birth?

___Difficulty breathing
___Low birth weight
___Fever or seizures
___Bruised anywhere
___Health problems
___Problems with bones/joints
___Required blood transfusions
___Nerve problems
___Infection
___Jaundice
___Intensive care

Does this/did this child have any birth defects? ___Yes ___No

If yes, what? _____

Describe what your child's temperament was like as an infant.

___Difficult ___Calm ___Sleepy ___Hyper sensitive
___Irritable ___Active ___Easily scared ___Frequent crying
___Sociable ___Cranky ___Happy ___Alert

During the first twelve months, was this child:

Difficult to get to sleep ___Yes ___No Irritable___Yes ___No

Difficult to be put on a schedule	___Yes ___No	Alert	___Yes ___No
Easy to comfort	___Yes ___No	Affectionate	___Yes ___No
Overactive/in constant motion	___Yes ___No	Sociable	___Yes ___No

Was the child breast fed? ___Yes ___No For how long? _____

When was solid food introduced? _____

Was there any evidence of food intolerances? ___Yes ___No

If so, to what? _____

DEVELOPMENTAL HISTORY

How old was the child when (s)he:

	Average Age	Approximate Age	If not sure, please estimate		
Sat	4-7 mos		Early	Average	Late
Walked	12-17 mos		Early	Average	Late
Toilet Trained	18-36 mos		Early	Average	Late
Said first words	12-17 mos		Early	Average	Late
Began using sentences	36-60 mos		Early	Average	Late

SPEECH AND LANGUAGE

Has his/her hearing ever been tested?	___Yes	___No
Does this child have a history of frequent ear infections?	___Yes	___No
Has (s)he ever had tubes placed in her/his ears?	___Yes	___No

Last hearing/audiology evaluation: PLACE_____ DATE: _____

Does this child have:

Any speech problems/difficulty speaking?	___Yes	___No
Have any trouble understanding what is being said to him/her?	___Yes	___No
Has (s)he ever had a Speech and Language Evaluation?	___Yes	___No

If yes, where? _____ When? _____

RESULTS _____

Has (s)he ever had Speech/Language Therapy?	___Yes	___No
Is (s)he currently receiving Speech/Language Therapy?	___Yes	___No

If yes, where? _____

Frequency: _____

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)?	___Yes	___No
Has (s)he ever had Occupational Therapy (OT) evaluation?	___Yes	___No
Is (s)he currently receiving OT services?	___Yes	___No

If yes, where? _____ Frequency: _____

Does (s)he have any gross motor problems (walking, running)? ___Yes ___No

Has (s)he ever had a Physical Therapy (PT) evaluation? ___Yes ___No

Is (s)he currently receiving PT services? ___Yes ___No

If yes, where? _____ Frequency: _____

Does this child use any adaptive devices (braces)? ___Yes ___No

If yes, please describe:

_____

_____

VISION

Has this child ever been to an eye doctor? ___Yes ___No

Most recent date: _____

Does this child wear glasses? ___Yes ___No

If yes, why? _____

Has this child ever been assessed for / diagnosed with:

___Binocular Vision ___Convergence Insufficiency

___Other Convergence Issues ___Fixation Issues

IMPORTANT: if a child wears glasses, please bring them to the appointment

MEDICAL HISTORY

Is the child regularly checked by the following:

___Medical Doctor ___Chiropractor ___Osteopath

___Naturopath ___Dentist ___Other

Has the child had the following childhood or other diseases?

___Bronchitis	___Allergies	___Abdominal Pains	___Pertussis	___Scarlet Fever
___Bed Wetting	___Asthma	___Croup	___Measles	___Meningitis
___Seizures	___Chronic Colds	___Colic	___Mumps	___Rubella
___Chicken Pox	___Ear Infections			

Does this child have/had braces on his/her teeth? ___Yes ___No

Does this child have any amalgam fillings? How many? ___Yes ___No

How many continuous hours is the child sleeping? _____

Is she/he well rested in the morning? ___Yes ___No

Does the child suffer from sleeping difficulties? ___Yes ___No

Does the child have problems with food/eating? ___Yes ___No

Is the child a fussy eater? ___Yes ___No

Does the child have issues with hygiene/cleanliness? ___Yes ___No

Does the child complain of any ongoing physical pains? (headaches, tummy aches, Muscle/joint aches, or growing pains) ___Yes ___No

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

Does the child suffer from dry skin, dandruff, hard skin on elbows, ___Yes ___No
bumps on the outside of the arms, cracked heels, excessive thirst/urination?
Has this child received vaccines? ___Yes ___No
If yes, please list:

_____

_____

Were there any of the following adverse reactions noticed? ___Yes ___No
___Inconsolable crying ___High fever ___Sleep disruptions afterward
___Lethargy ___Irritability ___Developed allergies

How many courses of antibiotics has this child received?

_____

Has this child taken any other prescription medication in the past? ___Yes ___No
If yes, what were they? _____

_____

Is the child exposed to a toxic environment (including passive smoking)? ___Yes ___No
Has the child had any serious falls, physical traumas, or physical injuries? ___Yes ___No
Please list: _____

_____

SCHOOL HISTORY

Does the child like or enjoy school? ___Yes ___No
If not, why not?

_____

_____

_____

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S___	W___	Math	S___	W___	Music	S___	W___
History	S___	W___	Science	S___	W___	Creative Writing	S___	W___
Gym/Sports	S___	W___	Other languages	S___	W___	Other:	S___	W___
Art	S___	W___						

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

Vocabulary and Expression	S___	W___	Reading quickly	S___	W___
Creative Writing	S___	W___	Memorizing	S___	W___
Getting assignments done on time	S___	W___	Spelling	S___	W___
Understanding concepts	S___	W___	Planning	S___	W___
Reading comprehension	S___	W___	Concentration	S___	W___
"Good" behavior	S___	W___	Handwriting	S___	W___
Test Preparation	S___	W___	Organization	S___	W___

Is getting homework done a struggle? ___Yes ___No

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

BEHAVIOR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____
_____
_____
_____

Indicate how many hours a week of "screen time" the child uses:

Computer _____ Smart Device (phone, iPad, etc.) _____
Computer games (DS, etc.) _____ Television _____

Describe the child's family relationships; with parents and siblings: _____

Does your child have many friends? ___Yes ___No

Does the child appear to excel at or struggle to build relationships with their peers?
___Excel ___Struggle ___Neither

If they struggle, why do you think that is? _____
_____

What problems does the child have with peers, if any?

___None ___Bragging to peers ___Being teased
___Being physically attacked ___Rejected by peers ___Overly physically affectionate
___Being bullied ___Jealous of peers

Does this child have self-esteem issues? ___Yes ___No

Which of the following has the child experienced in the last 12 months?

___Serious illness/injury in immediate family ___Change of school ___Mother pregnant
___Parents separation/divorce ___Move to a new home ___Parent losing a job
___Birth of a sibling ___ Death of immediate family member
___None ___Other: _____

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please check any that apply)

___Often touchy/easily annoyed ___Often bullies/threatens ___Often irritable
___Often defies adult rules ___Initiates physical fights ___Changes in appetite
___Often angry/resentful ___Ever been arrested ___Diminished interest
___Often argues with adults ___Physically cruel to others ___Sleep problems
___Often looses temper ___Physically cruel to animals ___Restlessness or slowed down
___Blames others for mistakes ___Motor or vocal tics ___Fatigues, low energy
___Deliberately annoys ___Destroys property ___Feels worthless
___Often spiteful/vindictive ___Deliberately sets fires ___Becomes tearful easily
___Refuses to go to school ___Lies often ___Often sad

___Repeated nightmares
___Unusual fears
___Panic attacks
___Self-conscious/clings
___Excessive need for reassurance
___Self-injurious behavior
___Worry of future events
___Repeats certain actions
___Somatic complaints (headache/stomach)
___Difficulty maintaining friendships
___Steals
___Has run away
___Extreme mood swings
___Does not show emotions
___Overreacts to touch/noise
___Strange to bizarre ideas
___Used drugs in the past
___Poor social interactions
___Gets upset by changes in routine
___Indecisive/can't think
___Thinks about death
___Talks about suicide
___Hurts self
___Currently uses drugs
___Currently drinks beer or alcohol
___Used beer or alcohol in the past
___Can't stop thinking about things
___Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes the child:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
Often has difficulty sustaining attention in tasks or play activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish schoolwork, or chores (not due to oppositional behavioral failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in other situation in which remaining seated is expected				
Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings or restlessness)				

Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or games)				

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name_____ Relationship to child_____

Date: _____/_____/_____

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

INSURANCE INFORMATION:

Member ID# _____

Insurance Company: ❑BC/BS (PPO) ❑Medicare ❑Coventry ❑United Health Care ❑ Aetna

❑Other _____

Policy Holder: ❑ self ❑spouse/partner ❑parent ❑guardian

_____

Policy Holder Name (if not self) DOB

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Heartland Chiropractic and Wellness Center all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

SIGNATURE

Acknowledgment of Heartland Chiropractic and Wellness Center Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me.
I also understand that this Notice is available at HeartlandWellnessCenter.com\Forms or by request.

_____

Signature of Patient or Legal Representative *Date*

_____

Print Name of Patient or Legal Representative

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

Acknowledgment of Heartland Chiropractic and Wellness Center Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me.
I also understand that this Notice is available at HeartlandWellnessCenter.com\Forms or by request.

_____

Signature of Patient or Legal Representative *Date*

_____

Print Patient Name

5521 NW 86th St. Johnston · IA 50131 · Phone: 515.252.8668 · fax: 515.270.2457 · info@hcwellness.com
www.HeartlandWellnessCenter.com

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER
515.252.8668 · HeartlandWellnessCenter.com
5521 N.W. 86th Street · Johnston, IA

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the

preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

_____

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

No Show and Cancellation Policy

Thank you for trusting your medical care to Heartland Chiropractic & Wellness Center. When you schedule an appointment with Heartland Chiropractic & Wellness Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Initial	Please read the following closely and initial when finished
x_____	**Cancellation & No Show Policy:** Heartland Chiropractic and Wellness Center has a 12-hour cancellation & rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 12 business hour notice, you will be charged $30.00. If you no-show or late cancel for two or more visits, you will receive a $50.00 fee. This policy is out of respect for our doctors and our patients in order to help as many individuals as possible. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
x_____	**Late Arrivals:** If you arrive late (10+ minutes) to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.
x_____	**Terms & Conditions:** I understand the terms of this form. I understand that these fees are not related to my insurance coverage, co-pay, or deductible and cannot be billed to my insurance company.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact Heartland Chiropractic & Wellness Center during our regular business hours with any questions or concerns regarding our policies.

515-252-8668 · info@hcwellness.com · 5521 NW 86th St. · Johnston, IA 50131
www.HeartlandWellnessCenter.com

Heartland Chiropractic and Wellness Center

5521 NW 86th St. Johnston, IA 50131
www.HeartlandWellnessCenter.com
ph: 515.252.8668 fax: 515.270.2457
info@hcwellness.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 19th, 2013

This Notice of Privacy Practices applies to the following organizations.

Heartland Chiropractic and Wellness Center Privacy Official:
Stephanie Sandvig, Office Manager steph@hcwellness.com 515.252.8668