

"A WELLNESS PLACE"

23 North Gore, Webster Groves, Suite 210 MO 63119~314-961-7605

www.awellnessplace.com

Personal and Family Health History

Date _____	Referred By _____
Name _____	Social Security # _____
Address _____	Occupation _____
City _____ State _____ Zip _____	Employer _____
Phone: (H) _____ (W) _____	Marital Status S M D W
(CEL) _____	Spouse's Name _____
Date of Birth _____ Age _____	Emergency Contact & # _____
E-mail _____	

Number of Children and Ages

Previous Chiropractic Care?

Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____
Name _____	Age _____	Yes ___ No ___	Reason _____

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____

~OVER~

3. Current Health Habits

Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Age of Bedding? ___ years Cellular Phone Usage Frequency _____ hrs./day

I am here for WELLNESS CARE _____

As a result of my chiropractic care, I would like to

Please check all that apply

- Feel better quickly
- Have a healthier body by keeping my nerve system healthy
- Have a healthier spine
- Live a healthier lifestyle

I am here for a Current Health Condition:

Present Complaint? (be brief) Reason For Your Visit Today: _____

Any Pain? or Problem started on _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Pains are: Sharp Dull Constant Intermittent

On a scale of 1-10 with 1 the best and 10 the worst, this complaint is a _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Have you been under drug and medical care? _____

What side effects have you experienced from the drugs and/or surgery? _____

Other symptoms:

- | | | | |
|--------------------------------------------|-------------------------------------------------|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible.

Signature

Date

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Context Of Care

Name: _____

Why did you choose to come to this clinic?

For your care to be a true WIN for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you think the signs and symptoms that you are experiencing could be purposeful? i.e. Could they be your body's wisdom saying, "I need some help... let's change something here!"

Do you feel your signs and symptoms are (1) a reflection of short term superficial circumstances or (2) longer term potentially deeper seated challenges? (Please circle your inclination here.)

What are the areas of your lifestyle that you would like to improve: (Circle, the prioritize #1, 2, 3, 4 etc.)

My level of anxiety

My place of living

Not enough quiet time

My diet and nutrition program

My social and family life

My communication skills

Time spent in nature

My creative expression

Not enough rest

My feelings around career

My exercise program

Other: _____

Self-destructive lifestyle habits: (please list) _____

(Over)

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (e.g. Percentage of vitality and/or longevity, percentage of joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to address any underlying causes of your signs and symptoms which relate to your lifestyle? Rate from 1 to 10, with 10 being 100% committed)

Reflect on your highest priorities in life and list the top 3 which come to your mind and speak to your heart. Where does your health and vitality factor in?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

How confident are you that you will follow through on the healthy lifestyle changes (e.g. Nutrition and exercise) that it will take to achieve your wellness goals/ (Rate 1 to 10, where 1 is "not at all" and 10 is "100% certainty".)

Which of the following services offered here are most interest you now, and which will be of interest as a later time: ('N' for now, 'L' for later)

- Chiropractic – new injury**
- Chiropractic – chronic injury**
- Chiropractic – Wellness care**
- Extremity adjusting for shoulder/arm/wrist problems**
- Infant and child care**
- Acupuncture**
- Meridian balancing**
- Biomeridian Testing**
- FCT – Field Control Therapy (see www.fctworld.com for more information)**

Field Control Therapy is a relatively new healthcare system that specifically addresses the illnesses of the 21st century. Modern lifestyle comes at a cost. Poor diet, increased exposure to radiation, environmental pollutants and toxic metals are creating a host of new health problems from chronic fatigue to immunodeficiency, autism and MS, to name a few. FCT identifies key toxins underlying illness and treats with 'causative homeopathy' to restore healthy cellular functioning.

Nutrition counseling

Massage

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. Acupuncture, nutrition and homeopathy are also utilized in the office to help assist the bodies' natural healing abilities.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Name of Patient _____ Date _____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This can be a normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact 'A Wellness Place' at **314-961-7605**.
7. Posture. Stand up straight, don't tilt or twist your hip. Don't slouch, do not cross your legs, sit straight. You've heard this all before. It is especially important during this stage of your care. When sleeping, lie flat on your back with a pillow beneath your knees and a small pillow, or no pillow, under your neck, as explained by the staff. When lying on your side, place a pillow under your top leg so your hip, thigh and lower leg are horizontal with your sleeping surface. Do not sleep on your stomach.

I have read and understand the instructions given for my follow-up care.

Patient's Signature

Date

Staff

Date

Office Policies & Procedures

_____ **1. Symptoms:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

_____ **2. Appointments:** A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours **so you stay on target for wellness.** *It is your responsibility to get here.* We will do all we can to accommodate you.

_____ **3. Daily Visit Procedure:** Each time you arrive for your adjustment, sign in and have a seat in the reception room until you are directed to an adjusting room by the front desk chiropractic assistant. Go back to the adjusting room and place a piece of face paper on the table, lay down on your stomach and relax until the doctor becomes familiar with your spine to adjust you. Once the doctor learns your spine, your adjustments will take only a few minutes and be very focused. Please help keep things moving by laying down quietly and relaxing for your adjustment. Our open environment allows you to receive your care quickly and efficiently with minimal waiting. Should you feel the need for a private adjustment or consultation, inform our staff and we will gladly accommodate you, at no extra charge of course.

_____ **4. Dynamic Examinations:** During your Initial Intensive Care you will receive several Dynamic Examinations to monitor your level of spinal correction. On this visit you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending approximately 30 extra minutes on these days. There is an additional fee for this visit unless you are on a Prepayment Plan that is all inclusive. Immediately following your Dynamic Examination, the doctor will sit down with you to discuss your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

_____ **5. Human Potential Program (HPP):** This is the single most important visit we provide because it is where you'll learn how to get the best results from Chiropractic. It is our policy that you attend one HPP within the first 2 weeks of care. We recommend that you bring your spouse, a family member, or friend with you so you can create a support group that understands what you're going through and keep you focused on your desired results. Also, if you know anyone else with a health problem, or who is committed to a wellness lifestyle, our HPP would be a great way to introduce them to our office and chiropractic without any obligation or financial commitment. The fee for your orientation is included in your exam fees. It is held on Wednesday evenings at 7:00.

_____ **6. Exercise:** Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, discs, and nerves. **However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced.** We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

_____ **7. Nutrition:** Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs on a daily basis. For more detailed information on nutrition, we highly recommend that you shop and consult with the (**insert local vendor here**), located at (**insert location**).

_____ **8. Results:** We are very results-oriented, however many factors that we have no control over may affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

PATIENT: _____ **DATE:** _____

WITNESS: _____

**Congratulations on choosing Chiropractic.
Follow through with your family, and enjoy the
health benefits that come with
a Chiropractic lifestyle.**

Office Fee Schedule and Financial Policy

(use if office does NOT file insurance)

<u>Service</u>	<u>Fees</u>
Consultation	No charge
Initial Exam with Computer Scans	\$75 - 135
Periodic Dynamic Exam	\$45
Adjustment	\$40 - 60
Therapeutic/Rehabilitative Services	\$15 - \$50
FCT	\$300 – 150
BIA	\$25

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your chiropractic report. Please choose one of the following documentation options:

- Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that insurance may not be used for Wellness Adjustment Plans.
- No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in a Wellness Adjustment Plan, you will be given a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, (name) _____ have read and I understand the above policies. I have initialed the receipt option that applies to me.

Patient signature

Date

DISCLAIMER

FYI: According to the Federal Food, Drug and Cosmetic Act, as amended. Section 201 (g)(1), the term drug is defined to mean: Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

In other words, to “say” that a vitamin, mineral, herb, botanical, homeopathic remedy, trace element, enzyme or amino acid will have any effect on disease or symptoms thereof, that particular nutrient then becomes a DRUG by law as written.

Therefore, be advised that any nutritional program/suggestions is not intended as primary therapy for any disease or symptom... but... is an adjunctive schedule of nutrients or ‘energetic water’ as utilized in homeopathy, provided solely to upgrade the quality of foods in the diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body, or to assist the body to return to homeostasis and energetically balance the human body.

Dear Geoffrey D. Norton, D.C.

By signing this paper I understand that any suggested nutritional program or dietary information is not intended as primary therapy for any disease or symptom. I understand that this dietary health program or homeopathic protocol is not for the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease. I understand that this is an adjunctive schedule of nutrients or ‘energetic water’ as utilized in homeopathy, provided solely to upgrade the quality of foods in the diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body, or to assist the body to return to homeostasis and energetically balance the human body.

Patient Signature: _____ Date: _____

Print Name: _____

Notice of Privacy Practices

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

Introduction

At Alternative Health & Wellness Center Mid-America, Inc., we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Alternative Health & Wellness Center Mid-America, Inc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health record, serves as a:

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

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, and why others may access your health information, and make more informed decision when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Alternative Health & Wellness Center Mid-America, Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524. If you request copies, we reserve the right to charge you a fee as permitted by Missouri State law.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information for reasons other than treatment, payment or health care operations, as provided in 45 CFR 164.528. If you request this disclosure more than once in a 12 month period, we reserve the right to charge you a fee as permitted by Missouri State law.
- Request communication of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Alternative Health & Wellness Center Mid-America, Inc., is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide a revised notice to you on your next visit.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Requests to Inspect Protected Health Information

As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing conditions, and providing treatment. For example, results of laboratory work will be available in your health record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include, but not limited to, services in a radiology department and certain laboratory tests. When these services are requested we may disclose your health information to our business associated so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For more information or to report a problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (314) 961-7605.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the Office for Civil Rights is:

Office for Civil Rights
U.S. Department of Health and Human Services
601 East 12th Street – Room 248
Kansas City, MO 64106
Voice phone (816) 426-7278
Fax (816) 426-3686
TDD (816) 426-7065