Balance Sport & Spine

3833 Fairfax Dr, Suite 110
Arlington, VA 22203

info@BalanceSportAndSpine.com
(202) 674-0644
www.BalanceSportAndSpine.com

Intake Form

Patient's Name______________________________ Birth Date: ____________ Age: __________
First Middle Initial Last

Street Address, City, State and Zip Code: ____

Email ______________________________ Home Phone (__) ________ Cell Phone (__) ___________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security #: ______________ ☐ Male ☐ Female

Date of present illness/injury: ___/ ___/ ____ Name of Referring Doctor:____________________________

Who may we thank for referring you (if non-physician)?____________________________________

Employer/Occupation: _________________________________ Work Phone Number: (__)________
Employed: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Working

Spouse's Name: __________________________ Spouse's Employer: _______________________

Contact in case of emergency: ____________________________ Phone number: (__) ___________

Appointment reminders are sent out the day before your appointment. Reminders are delivered through an automated system which will leave a message at the communication method selected below (please do not leave a contact that may be viewed/received by unauthorized parties).

I would like my reminder via: ☐ Email ☐ Phone ☐ SMS (Text) msg ______________________________
Reminder Phone/email/text information here

The communication method selected above is authorized to receive automated appointment reminders: ____________________
Patient Signature

In order to efficiently check you in at the time of your first visit, we request that you please send this paper work back to us at least three days in advance of your first appointment via fax at (571) 665-6691.

We appreciate your business and look forward to meeting you! If you have any questions in the interim prior to your appointment, please contact our office, our receptionists are ready to help you!

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Intake Form—page 2

We would like to welcome you to Balance Sport & Spine. Please take a few minutes to tell us about yourself and your medical history so that we may provide you with the best care possible. Please be sure to complete this form to the best of your knowledge. If you have any questions, don't hesitate to ask for assistance from the receptionist.

Patient's Name____
First Middle Initial Last

☐ Male
☐ Female

Name of Primary Care Physician and Practice Name:________________________________

Chief Complaint:
What is the reason for your appointment today (if multiple regions, please list in the order of severity of symptoms, from highest to lowest pain level): ________________________________

____

History of Present Problem:
When did this problem start (if multiple regions, please list a date/time period for each one): ________________

____

____

Have you ever had these symptoms or similar symptoms in past? ☐ Yes ☐ No
If yes, when? (if multiple regions, please address each one):________________________

____

____

____

Have you ever had Physical Therapy before? ☐ Yes ☐ No If yes, when? ____________ Location:____________
Have you ever had A.R.T. before? ☐ Yes ☐ No If yes, when? ____________ Location:____________
Have you ever had Chiropractic Therapy before? ☐ Yes ☐ No If yes, when? ____________ Location:____________
Have you seen any other Doctor for this condition?

Doctor seen	Tests Done	Results	Treatment given/Approximate date	Helpful?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Since the onset of the problem, has it improved? ☐ Yes ☐ No How much?_____% Most successful therapy? ____________

What exercises do you currently do that you find helpful? ________________________________

____

What stretches do you currently do that you find helpful? ________________________________

____

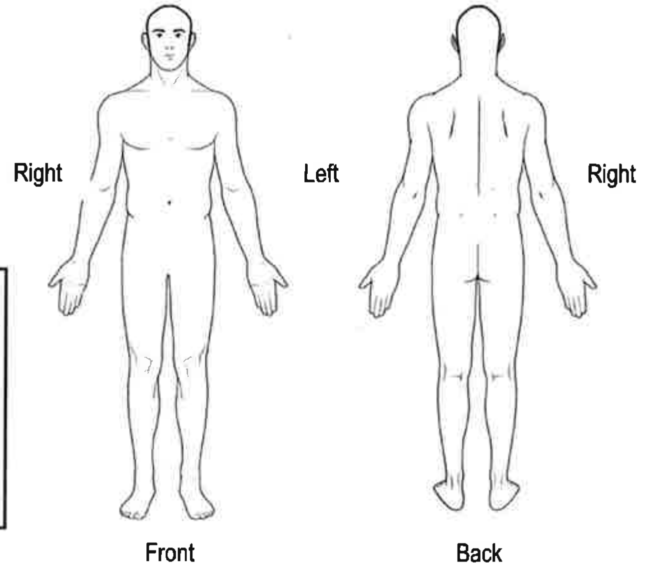
Indicate work status: ☐ Regular Duty ☐ Light duty ☐ No work because of this problem (please list dates off work): ____________

Please use the diagram to the right to indicate the most significant pain.

Draw an X for the location of the pain.

Circle areas of numbness and/or tingling.

Use → to show if pain travels from one area to another.



Please circle a whole number on the below diagram to indicate current pain level (if multiple regions, indicate the region associated with the number circled).

0 = No Pain, 10 = the highest level of pain

0----1----2----3----4----5----6----7----8----9----10

Please describe any scars on your body (include major and minor ones): ____________________

____

Is your pain: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Stabbing ☐ Burning ☐ Other ____________

Do you experience (indicate region corresponding to symptom on the line following the description, if multiple sites):
☐ Numbness ____________ ☐ Burning ____________ ☐ Tingling ____________
☐ Cramping ____________ ☐ Other symptoms? ____________
What activities or motions decrease your symptoms? ____________________

____

What activities or motions increase your symptoms? ____________________

____

Office use: length of time prior to aggravation onset for each activity: ____________________

____

Medications
Please list all medications, including over-the-counter medications and/or supplements: ____________

____

____

Water consumed per day? ________ ounces Medication or Other Allergies: ____________

Past Medical History: Please check any of the following that apply (currently or in past):

☐ Arthritis ☐ Blood Clots ☐ Cancer (indicate type) ________ ☐ Coronary Artery Pressure ☐ Diabetes
☐ Fracture/ Broken Bones (indicate region) ________ ☐ Gastrointestinal Issues (indicate type) ________
☐ Headache (indicate type) ________ ☐ Heart Attack/ TIA ☐ High Blood Pressure ☐ History of Back pain
☐ History of herniated disk (indicate level) ________ ☐ HIV/AIDS ☐ Joint replacement (indicate region) ________
☐ Kidney Disease ☐ Neurologic Disorders ☐ Peripheral Vascular Disease ☐ Pinched Nerves (indicate region) ________
☐ Seizures ☐ Stroke ☐ Thyroid Disease ☐ TMJ

Please list any other past or present medical conditions: ____________________
Please indicate any prior accidents/traumas (include any fractures or consequent areas of injury): ____________

____

Past surgical history: ____

Family history: Please list all diagnosed medical conditions that are common in your family: ____

____

Social History:

History of

□ tobacco use (how often and amount consumed?) ______________________

□ alcohol use (how often do you drink per week? Number of drinks per occasion?) ______________

□ Do you have or have you had issues with drug/alcohol use or dependency? □ Yes □ No

Review of Systems—Please indicate any of the below that are <u>currently</u> presenting problems:

General:	□ Weight Changes	□ Appetite changes	□ Fever	□ Fatigue	□ Sleep Disturbances
Eyes:	□ Vision	□ Discharge	□ Pain	□ Glaucoma	□ Cataracts
Ears, Nose, Throat:	□ Hearing	□ Swallowing	□ Nasal Congestion		□ Hoarseness
Cardiovascular:	□ Chest Pain	□ Fainting	□ Leg Swelling	□ Racing Heart	□ Cramping
Respiratory:	□ Shortness of Breath		□ Cough	□ Wheezing	□ Asthma
Gastrointestinal:	□ Ulcers	□ Diarrhea	□ Constipation	□ Heartburn	□ Acid Reflux
Urination	□ Frequency	□ Urgency	□ Painful Urination	□ Decreased Stream	
Skin:	□ Plaques	□ Color Change	□ Lesions	□ Rashes	□ Dryness
Endocrine:	□ Heat/Cold Intolerance		□ Nervousness	□ Lethargy	
Hematological	□ Bruising Easily	□ Anemia	□ Uncontrolled Bleeding/ Difficulty Clotting		
Psychiatric:	□ Depression	□ Mania	□ Anxiety	□ Prior diagnosed psychological condition ____________	
Neurologic:	□ Seizures	□ Balance Issues	□ Muscle weakness due to nerve deficit		
Musculoskeletal:	□ Pain □ Spasm	□ Cramps	□ Joint Swelling	□ Redness	□ Stiffness

I have read and completed the above form and certify that the above information is accurate to the best of my knowledge

Patient Signature: ______________________________________ Date: ________

If signing on behalf of a patient:

Patient Printed Name ______________________________________ Date: ________

Authorized Signature: ______________________________________

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PRIOR IMAGING

Imaging is helpful at providing our office insight into your condition. We do not recommend imaging of an area unless medically recommended based on your symptoms, which your Doctor will advise you on at the time of your appointment. However, **if you have previously had imaging performed of your current painful/symptomatic region, you will need to bring a copy of this with you to your appointment.**

Have you had previous imaging performed of your current area of complaint? ☐ Yes ☐ No

If so, at which facility did you have your imaging taken? ______________________________

Phone number of the facility (if available): ______________________________

Do you have a copy of the imaging on CD currently? ☐ Yes ☐ No

Will you be bringing the imaging/CD to your initial appointment? ☐ Yes ☐ No

If yes to CD, please arrive 20 minutes prior to your appointment and give the CD to receptionist upon check-in.

Do you have a radiology report for the applicable imaging? ☐ Yes ☐ No

If yes, please select one of the following options:

- ☐ I am including a radiology report with my fax of intake forms to your office
- ☐ I am requesting the office holding the report fax it to your office
- ☐ I am bringing a copy of the report to my appointment

Is there anything else you would like us to know regarding imaging of your area of complaint?

____
____
____
____
____

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PATIENT INFORMATION SHEET

Thank you for trusting your care to Balance Sport & Spine, we look forward to meeting you! The following form is designed to welcome you to our practice and briefly familiarize you with Dr Backus, her training, and our general office policies, and to enable the best dynamic for caring for your condition.

About Balance Sport & Spine, and Dr Backus:
Dr Backus specializes in pain conditions of the entire body, including the back, neck, and extremities (shoulder, elbow, knee, ankle, foot etc). She uses a comprehensive understanding of the body's mechanics, musculoskeletal system, and nervous system to treat simple as well as complex; acute or chronic pain conditions. We **have had success where other treatments have failed for many of our patients.** **Education:** Dr Backus received her undergraduate degree from the University of Virginia (2000, Psychology), a degree in Business Administration Program through Georgetown University's School of Continuing Studies (2006), and a Doctorate of Chiropractic degree from Life University (2013). In 2013, she became licensed through the Virginia Board of Medicine as a Chiropractic Physician. In 2013, she was vetted through the Physician's Services Program at Virginia Hospital Center and her practice accepted to be located at Virginia Hospital Center McLean Medical Group. Following four wonderful years at this location, she began another practice at INOVA Medical Group in 2017. **Approach:** In addition to her knowledge as a Chiropractic Physician, Dr Backus has pursued and achieved Board-Certification in Physiotherapy through the NBCE, as well as pursued rigorous training in Active Release Technique (ART), a medically patented Soft Tissue Technique and is licensed to perform Complex Protocols for the Full Body. She daily integrates her knowledge of each pain condition to care in a one-on-one environment for her patients, to help them make the best progress possible with their pain conditions and continues to pursue regular continuing education on the latest practices in her field.

Appointment preparation: In order to best treat your condition, please wear comfortable clothing which allows free movement (workout clothes which do not obstruct viewing of the region, and athletic shoes) to each appointment. We aim to provide the best possible care for your condition and it is essential to easily view the area during movement patterns, as well as be able to easily access the area during your appointment. **Please ensure that you are changed and ready when you arrive for your appointment.**

First Office Appointment (New Patient Evaluation):
A complete understanding between yourself and your Doctor of your pertinent information/ history is essential in assessing your condition properly. Your accurate and full completion of the intake paperwork in this packet, and open communication between yourself and your provider at each of your appointments is paramount, and we greatly appreciate your taking the time to carefully complete your intake forms, detailing the history of your painful condition.
Your first visit is a 50-minute appointment, during which time your Doctor will collect further details surrounding your pain condition, as well as perform an evaluation, including appropriate testing. This appointment is an **evaluative appointment** to appropriately assess your condition, including collecting objective findings such as range of motion limitations and painful positions to acquire a base-line understanding of your condition. If no further imaging or testing is required at this time, your assessment will be used to determine your pain generator and deliver a correct diagnosis to best treat your condition for future appointments. The expected length and frequency of future appointments, as well as treatment options and therapy at our office will also be discussed.
This appointment is also designed to answer your questions relating to your condition. **Future appointments will focus exclusively on treatment, versus continued explanation of your condition, so questions are appreciated and encouraged at your first appointment time.**
Your Doctor will also explain to you the ways to accurately track your pain condition between upcoming visits including:

1) Keeping a daily journal of pain levels: Rate your pain on a 0-10 pain scale. These are subjective measurements by the patient and are necessary to express to your Doctor your unique pain experience between appointments,
2) Location of the pain (i.e. where on the right knee your pain is located—front/back/inside/outside of the knee),
3) As well as timing of the pain (is it worse in the morning, evening, after exercise, after a particular activity),
4) As well as the frequency of the pain (occasional, constant, intermittent—percentage of time present, if intermittent?).

You will be asked to keep track of this information between appointments and report to your Doctor at the beginning of each future appointment, prior to beginning your treatment for that day. We aim to help you achieve good progress and this process is collaborative and requires your feedback and participation to ensure appropriate progress between appointments. Because pain typically follows a pain pattern of being at high levels to gradually lower levels, maintaining this data between appointments is important in our assessment of your progress.

Future appointments (following New Patient Evaluation at 1st appointment): Your appointment length is established based upon the number of services and associated length of office time to address your symptoms at each appointment–**establishing the correct amount of time in office is essential for your proper progress, which is our aim.** The below fees detail typical office visit lengths and associated charges. You agree to pay the session fee in full at the end of each appointment. Our fees for appointments are as follows:

CATEGORY 1 15-23* minute appointment: $80
CATEGORY 2 25-38* minute appointment: $120
CATEGORY 3 40-55* minute appointment: $160
*** Time variability is dependent on the time necessary to perform the services specified for your condition in-office—this is intended to provide a general outline for patients of office appointment length and associated cost, at any given appointment.**

Communication between appointments with your Doctor:
Typically it will not be necessary for you to communicate directly with your Doctor between appointments, only with our staff regarding scheduling/routine office matters. Should you need to speak with your Doctor, our preference is for all Doctor/patient interactions to occur in-office. It is easy to misinterpret or misunderstand intent/context when reading an email, and not possible for a Doctor to physically assess the patient and provide advice via email or over the phone. In addition email is not confidential and so goes against the patient's right to privacy with regards to his/her medical information. Please call our office to schedule an appointment if you need to follow up with your Doctor between appointments.

We ask that if you are speaking on the phone with your Doctor that your conversation be kept brief, less than 10 minutes. If we exceed 10 minutes, standard appointment rates will be applied.

Emergencies
We do not provide emergency services. Medical emergencies are life threatening events that require prompt medical attention—call 911 or go directly to your nearest emergency care center.

Other Fees:

- Telephone call—No charge for first 10 minutes, after that standard appointment rates apply.
- Standard appointment rates apply for time spent outside of appointment on email, legal matters, or other client related business (including coordinating care with other Doctors, requested by patient or deemed necessary for proper patient treatment) beyond 10 minutes per week.
- Copying charge: $0.25/ page
- Returned check fee--$25
- Missed appointments cancelled less than 24 hours in advance will be charged the full appointment fee for the length of the appointment scheduled.
- If you are late to an appointment, you agree to pay full appointment fee for the length of the appointment scheduled.

Record requests/Written communication—outside of routine scheduling requests, the office reserves the right of a minimum of 5 business days (dependent on the nature of the request) to respond to written requests for medical communication–requests for written communication including the transmitting of medical records will be a minimum of 10 business days.

Insurance Reimbursement: It is our goal to ensure clear communication about all financial policies, including insurance. Balance Sport & Spine is an "out-of-network provider," and we do not accept insurance, some insurance companies will partially or fully cover our services, some will not. If this is a concern for you, please check with your insurance company regarding your eligibility for benefits. We cannot guarantee that your treatment will be covered. If you would like to use your insurance, you agree to request, as needed from our office, an "itemized insurance claim" that you may submit to your insurance for reimbursement. We do not call or correspond with your insurance company, or provide additional paperwork. You will still be responsible for payment in full at the end of each session, and your insurance company will reimburse you directly. (Please note: The "receipt of payment" you may receive for payment is different from the "itemized insurance claim" form.)

Attention Medicare/Medicaid patients: Please advise the doctor immediately if you are a Medicare or Medicaid patient and check the box to the right indicating which plan is applicable. Dr Backus is a "Non-Par Medicare Provider"—see "Medicare" Form of this packet for further details.

☐ **Medicare** ☐ **Medicaid**

I acknowledge and agree to abide by the above office policies/ guidelines during my treatment at Balance Sport & Spine, LLC.

Printed Name

Signature Date

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Informed Consent For Treatment
(Including ART, Manipulative, and Rehabilitative Therapies)

I have been informed of the nature and purpose of care through Balance Sport & Spine, the possible consequences of care, and the risks of care, including the risk that care may not accomplish the desired outcome. In such cases, I will be appropriately referred to another healthcare professional to continue treatment toward my desired outcome.

Reasonable treatment alternatives have been explained, including risks, consequences, and probable effectiveness of each alternative treatment.

In addition, I have been advised of possible consequences if no care is received for my condition.

I acknowledge that no guarantees have been made to me concerning the results of care or treatment.

I have read the above statements. I understand the information provided. All questions I have about this information have been answered to my satisfaction.

I authorize Balance Sport & Spine to begin treatment including, as appropriate: ART, manipulative, and rehabilitative care for my condition.

____
Printed Name

____ ______________
Signature Date

Parental Consent for a Minor Patient:

Patient Name: ____________________________________
Patient age: ______ Patient Date of Birth: ______________

Printed Name of person authorized to sign for Patient: ____________________
Signature of person authorized to sign for Patient: ____________________
Relationship to Patient: ____________________
Remarks: ____________________________________

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Credit Card Information

We require a valid credit card be kept on file through our secure system during your treatment course. This helps us in facilitating check out following your appointment, and will enhance your patient experience at our office. You will only be billed following your appointment, or if there is a violation of the 24 hour cancellation policy (see Patient Information Sheet). We offer the option to either complete the following form and return it at this time with your Patient Intake Information (preferred), or you may provide your credit card in person to our staff at your first appointment for entry into our system at that time. **Please note**: We appreciate your completion and return of this form with your card information **in advance with your Patient Intake forms**, as this facilitates our staff time and allows us to offer you faster service and **avoid delay** at your first appointment.

Please be prepared to provide at your first appointment 1) a valid form of ID (drivers license, passport, etc), 2) your insurance card(s) *, 3) and your credit card.

Name on Card (First, MI, Last): ______________________________

Type of Card (Visa, Mastercard, AMEX): ______________________________

Number on the Card: ______________________________

Expiration Date: ______________________________

CVV code (3-digit number, typically on the back of the card): ____________________

Zip Code associated with the billing address of the card: ____________________

*Insurance Card: Although we are out of network, we must keep a copy of your insurance information on file, should we be required to reference it.

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Balance Sport & Spine, LLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change.

____ ________________________
Signature of Patient/ Patient Representative Date

____ ________________________
Name of Patient/ Patient Representative (please print) Relationship to Patient

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Medicare Form

The following form should only be completed by Medicare patients—if you are not a Medicare patient, do not complete this form.

Medicare/ Insurance: It is our goal in the office to ensure clear communication about all financial policies. Dr. Backus is a "Non-Participating" Medicare provider.

Medicare Patients:

The initial exam ($160) is not a covered Medicare benefit and will not be paid for by Medicare.

All other visits (typically $80) are billed as "Active Release Myofascial"—code 97140, and "Therapeutic Exercise by a Chiropractor"—coded 97110 and are not covered under Medicare.

Secondary Insurance Coverage:

If you are insured by a secondary (or tertiary) party beyond your initial Medicare health coverage, your visit may be covered by this insurance (following initial denial by Medicare)—please contact your insurance carrier to inquire into their coverage of "Active Release/Myofascial"—code 97140, "Therapeutic Exercise by a Chiropractor"—coded 97110. We will submit on your behalf, at your request.

I understand and agree to abide by the above information during my treatment at Balance Sport & Spine.

Printed Name ______________________ Date ______________________

Signature ______________________

Please see the Front of Your Medicare Card to complete the below information:

Medicare Claim Number/Policyholder number: ______________________

Please Check box(es) below Indicating the Plan(s) you are Eligible for Under your Medicare Policy (see front of Medicare Card "Is Entitled To"):

- ☐ Part A — Effective Date: ______________________
- ☐ Part B — Effective Date: ______________________
- ☐ Part C — Effective Date: ______________________
- ☐ Part D — Effective Date: ______________________

Is Medicare your primary Insurance? ☐ Yes ☐ No If no, who is your primary Carrier? ______________________

Please see your associated Secondary or Tertiary Insurance Cards to answer the below questions:

Secondary Insurance ______________________ Member ID#____________ Grp ID# ____________
Subscriber's Name ______________________ Relationship ____________
DOB ____________ Subscriber's Social Security # ______________________

Tertiary Insurance ______________________ Member ID#____________ Grp ID# ____________
Subscriber's Name ______________________ Relationship ____________
DOB ____________ Subscriber's Social Security # ______________________

If you have any questions in the interim prior to your appointment, please contact our office, our receptionists are ready to help you!

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NOTICE OF PRIVACY PRACTICES

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

The confidentiality of your health information is very important to us. Each time you visit, a record is made of your care. Typically this record contains your symptoms, examination/test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care and the associated privacy practices in place for your protected health information.

Disclosure of Your Health Care Information (We may disclose the following)

- **Treatment:** Your health care information to other healthcare professionals for the purpose of treatment, payment or healthcare operations.
- **Emergencies:** Health information to notify or assist in notifying a family member/emergency contact responsible for your care about your medical condition in the event of emergency.
- **Individuals Involved in Your Care or Payment for Your Care:** We may release health information about you to your personal representative or a designated family member who is involved in your care. We may also give information to someone who helps pay for your care.
- **Public Health:** As required by law, health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, reporting disease or infectious exposure.
- **Judicial and Administrative Proceedings**: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process, but only if like notice has been given to you or your attorney in accordance with applicable law.
- **Law Enforcement:** Your health information to law enforcement officials for purposes such as identifying or locating a fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- **To Avert a Serious Threat To Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of the public, to you, or to another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Minors:** If you are an unemancipated minor under Virginia law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal responsibilities.
- **Deceased Persons:** Your health information to medical examiners/ applicable medical staff.
- **Incidental Uses and Disclosures:** There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. For example, our staff or physician may need to use your name to identify you in the waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.
- **Research:** Your health information to researchers conducting research that has been approved by an Institutional Review Board.
- **Specialized Government Agencies:** Health information for the military, national security, prisoner and government benefit purposes.
- **For Contacting you about services:** We may use your health information: to give an appointment reminder for treatment; to contact you to tell you about possible treatment alternatives; to contact you for marketing purposes.
- **Change of Ownership:** In the event that Balance Sport & Spine, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.
- **Your Health Information Rights:** Although your health record is the physical property of Balance Sport & Spine, LLC, you have the following rights regarding the health information we maintain about you:
  - You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care or payment for your care. We are not required to agree to your request, with one exception explained in the next paragraph, but we will let you know whether we have agreed to your request.
    - We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes if (1) you pay out-of-pocket in full for all expenses related to that service at the time of service and (2) the disclosure in not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.
  - You have the right to have your health information received or communicated through an alternative method when it is being sent to an alternative location (other than the usual method/location of communication or delivery), upon your request.
  - You have the right to inspect and copy health information. We may charge a cost-based fee for producing copies, including the cost of retrieving, copying, mailing, and use of supplies associated with your request.

- If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You must provide a reason for your request. We have the right to deny your request. If this occurs, you will be notified in writing of the reason for the denial, and of your right to submit a statement disagreeing with the decision, which will be added to your records.
- You have the right to request that we communicate with you about matters pertaining to your care in a certain way or at a certain contact location. We will agree to the request to the extent that it is reasonable for us to do so.
- You have the right to receive notice of an access, acquisition, use or disclosure of your health information that is not permitted by HIPAA, if such access, acquisition, use or disclosure compromises the security or privacy of your Protected Health Information (referred to as a 'breach'). We will provide such notice to you without unreasonable delay after we discover the breach.
- You have a right to receive an accounting of disclosures of your protected health information. This is a list of the disclosures we made of health information about you. The accounting will not include certain disclosures, such as those made for treatment, payment, or health care operations and certain other types of disclosures (for example disclosures in accordance with your authorization).
- You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
- To exercise any of your rights, please submit your request in writing.

- **Changes to this Notice of Privacy Practices:** We reserve the right to amend this Notice of Privacy Practices. We reserve the right to make revised or changed notice effective for treatment information we already have about you as well as any information we receive in the future. Until such amendment is made, we will comply with this Notice.
- **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with Balance Sport & Spine, LLC (our contact information appears at the top right of the first page). Complaints must be submitted in writing. If the office is not able to fully alleviate the matter, you may direct your complaint to the Secretary of the U.S. Department of Health and Human Services.