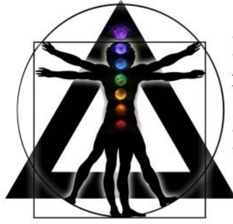


North Georgia Center
for the Healing Arts
21 High Park Dr. St. 8
Blue Ridge, GA 30513
706-946-5433

New Practice Member Application

Full Name ____ Date___________ Gender: M F

Address __________________________________City________________ State____ Zip________

Phone (Home) __________________ (Cell) ___________________ (Work) __________________

Email Address ______________________________ (for schedule changes, newsletters)

Date of Birth __________________________ Age______ Single____ Married____ Widowed____

Spouse's Name _______________ Children's Names and Ages ____________________________

____

____

Occupation__________________________ Previous Chiropractic care? **N / Y** When?_________

What have you heard about chiropractic?____

____

Who may we thank for referring you? ____

Reason for visiting our office ____

____

Anything I should know about your spine and nervous system? ______________________________

____

Previous traumas, injuries or accidents? ____

____

Previous Surgeries/ Hospitalizations?

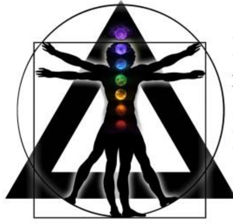
____

Any other medical conditions? ____

____

What do you enjoy doing when you are not working?

____



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Practice Member Agreements

Acknowledgment of Fees
The practice member acknowledges that these are cash fees and no 3rd party insurance or Medicare will be billed or accepted. We do not bill patients insurance or Medicare for any procedures performed in this office. This includes manipulation of the spine and its articulations. We charge a fee for the Applied Kinesiology examination and the doctor's time for proper evaluation. The adjustment itself, if or when it's performed to anyone regardless of benefits does not carry a fee, and therefore no reimbursement through Medicare is possible. Medicare does not cover muscle testing as performed through Applied Kinesiology methods. Medicare also does not cover Functional Medicine, Functional Immunology or Nutritional Supplements. As an elective care office, we do not participate in any lawsuit, medical case, opinion or testimony unless required by law to do so. We do not accept any personal injury, slip and fall or workman's compensation cases.

Visits
All visits are to occur during regular office hours, or unless special appointment is made ahead of time in office or over the phone. Due to the special nature of the practice, it is necessary for Dr. Smith to occasionally take time away from the office for Applied Kinesiology related events, including elective and mandatory continuing education courses and speaking events in the local community. North Georgia Center for the Healing Arts will make a sincere effort to notify all members of any changes to adjusting hours in advance by way of phone and online for patients with an already scheduled appointment.

Recommendations
Members are recommended non-therapeutic monthly spinal checks (elective care), regardless of how you may feel. Pain is not necessarily an indicator of when there is vertebral subluxation present and many other health issues that arise in the body do not necessarily carry the symptom of pain. Office visits do not necessarily mean you will receive a chiropractic adjustment, but are used to determine if vertebral subluxation is present and adjust when necessary.

This Plan is Not Insurance
This agreement does not constitute insurance. The care offered in this office is non-incidental, elective care provided in a non-therapeutic mode based on the practice member coming in <u>regularly</u> to be checked to be evaluated through Applied Kinesiology muscle testing.

Release of Endorsement
North Georgia Center for the Healing Arts has consent to send emails and texts regarding various events, updates and services and office schedule changes, when they occur.

I Have Read the Agreement, Had the Opportunity to Have Questions Answered and Accept the Terms.

Full Name ____ Date Signed ___________________

Signature ____ Date Signed ____________________

North Georgia Center
for the Healing Arts
21 High Park Dr. St. 8
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Terms of Acceptance/ Consent to Treat:

When a person seeks the services of a Chiropractor or Applied Kinesiologist, it is essential he/she fully understands the objectives of that chiropractor.

Chiropractic as it applies to this office has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the application of a gentle and specific force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and its vertebra.

Vertebral Subluxation: A misalignment of one of the 24 vertebra in the spinal column that causes alteration of nerve function and interference to the transmission of neuronal impulses, resulting in a decrease of the functionality of what that nerve root innervates (muscle, tissue, organ etc.)

We do not offer to diagnose or treat or cure any disease or medical condition other than vertebral subluxation. Nor do we offer advice regarding treatment prescribed by other medical healthcare providers. **THE ONLY PRACTICE OBJECTIVE** is to eliminate structural interference of the body's spinal column and facilitate the body's natural healing. Our method is specific adjusting to correct vertebral subluxations as found through manual muscle testing.

HIPAA Privacy Practices

Your private healthcare information will not be shared with anyone unless you have a signed form to release your records that is signed by you, or your legal guardian, or if required by law to do so. I authorize North Georgia Center for the Healing Arts to use a telephone or email to use my name, address and phone number for the limited purpose of contacting me to notify me of pending office related communications. I also authorize my chiropractic provider to disclose to third parties (i.e. family members at home etc.) who may answer my phone to leave a reminder message with them or on my voice mail system and/or answering machine if necessary.

I, ____have read and agree to the above terms. I have also had the opportunity to ask questions about any content in the Terms of Acceptance/ Consent to Treat. I therefore accept the chiropractic assessments and consent to treat on this basis.

Signature: ____________________________________ Date: ________________________

Consent to evaluate and adjust a minor child (if necessary)

I, ______________________________being the parent or legal guardian of

____

____

__________________ Date:___________________

CASE HISTORY

Today's Date:					**Dr. C.J. Smith D.C., CFMP, PAK**
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	Age:	DOB:	Sex: ☐ Male ☐ Female

HISTORY			
Are your present problems due to an injury?	☐ Yes ☐ No	☐ On the Job ☐ Auto Accident ☐ Personal Injury	☐Other:
Has the accident been reported?	☐ Yes ☐ No	☐ To Employer ☐ Auto Carrier	☐Other:
Are you now or have you ever been disabled? (Service Work)	☐ Yes ☐ No	When:	Why:
Have you retained an attorney?	☐ Yes ☐ No	Name:	Address:

List any accidents or falls and dates: ☐ Car: _________________________________ ☐ Recreation: _________________________

☐ Sports: _______________________ ☐ School: ______________________________☐ Other: ____________________________

List any broken bones (fractures) or dislocations: ____

Ever on crutches? ☐ Yes ☐ No, Why? ____

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No When? ____________ By Whom? ____________________

Have you ever had an X-rays made? ☐ Yes ☐ No, When? ____

For what ailments were these X-rays made? ____

Do you suffer from any condition other than that for which you are now consulting us? ____________________________________

Are you presently taking any medication – prescription or over-the-counter? ☐ Yes ☐ No List:

Habits	Exercise	Family History
Smoking: ☐ Yes ☐ No If so, how many packs?	☐ None ☐ Light Activity	Mother: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: ____________________ Father: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: ____________________
Drinking: ☐ Yes ☐ No Alcohol:	☐ Moderate Activity ☐ Active	Brother: # of: ☐ Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: __________________________
Caffeine: ☐ Yes ☐ No If so, how many cups?	☐ Very Active ☐ Elite Athlete	Sister # of: ☐Diabetes ☐ Heart ☐ Kidney ☐ Cancer ☐Other: __________________________

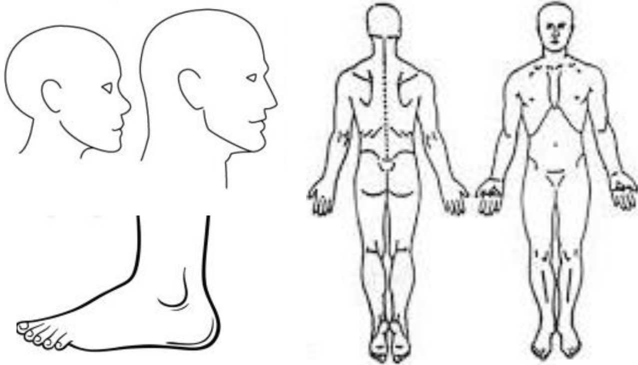
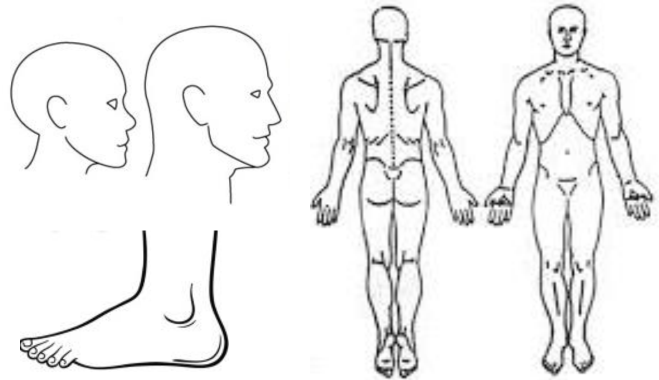
OPERATIONS AND PROCEDURES

Date	Procedure	Date	Procedure	Date	Procedure
	Vaccinations		Tubes in Ears		Sinus
	Tonsillectomy		Appendectomy		Hernia
	Gall Bladder		Female Organs		Thyroid
	Back Operation		Rectal Surgery		Stomach
	Other:		Other:		Other:

☐ I have never had any operations/procedures/surgeries.

PAIN CHART

Pain Symptoms:	1.	Began-(Mo/YR)	Previous Episodes:
(In Order of Severity)	2.	Began-(Mo/YR)	Previous Episodes:
	3.	Began-(Mo/YR)	Previous Episodes:

Please mark the intensity of you pain today. 1st Visit 0- No Pain 10- Intense Pain	Please mark the intensity of you pain today. 2nd Visit 1- No Pain 10- Intense Pain
Example: ________NECK____________________ 1 2 3 (4) 5 6 7 8 9 10	Example: ________NECK____________________ 1 2 3 (4) 5 6 7 8 9 10
1. ____________________________ 1 2 3 4 5 6 7 8 9 10	1.____________________________ 1 2 3 4 5 6 7 8 9 10
2.____________________________ 1 2 3 4 5 6 7 8 9 10	2.____________________________ 1 2 3 4 5 6 7 8 9 10
2 ____________________________ 1 2 3 4 5 6 7 8 9 10	3.____________________________ 1 2 3 4 5 6 7 8 9 10
Please mark area & type of pain on the drawing using the codes listed N – Numbness P – Pain T – Tingling A – Ache S – Soreness ST - Stiffness	Please mark area & type of pain on the drawing using the codes listed N – Numbness P – Pain T – Tingling A – Ache S – Soreness ST - Stiffness
	

Doctors Use Only	Doctors Use Only

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ 541 Appendicitis	☐ 280 Anemia	☐ 429.9 Heart Disease	☐ 716 Arthritis
☐ 480 Pneumonia	☐ 055 Measles	☐ 240 Goiter	☐ 345 Epilepsy
☐ 390 Rheumatic Fever	☐ 072 Mumps	☐ 487 Influenza	☐ 319 Mental Disorder
☐ 045 Polio	☐ 052 Chicken Pox	☐ 511 Pleurisy	☐ 724.2 Lumbago
☐ 011 Tuberculosis	☐ 250 Diabetes	☐ 303.9 Alcoholism	☐ 690 Eczema
☐ 033 Whooping Cough	☐ 239 Cancer	☐ 099 Venereal Disease	☐ 042 HIV Positive
☐ 493.3 Asthma	☐ 346.9 Migraine Headaches	☐ 054.9 Herpes	☐ 340 Multiple Sclerosis

Please check the correct box for each item below. Check at least one box for each or symptom listed.

Never	Previously	Presently	**General Symptoms**
☐	☐	☐	995.3 Allergy:
☐	☐	☐	780.9 Bronchitis
☐	☐	☐	780.9 Chills
☐	☐	☐	780.39 Convulsion
☐	☐	☐	780.4 Dizziness
☐	☐	☐	780.2 Fainting
☐	☐	☐	780.79 Fatigue
☐	☐	☐	780.6 Fever
☐	☐	☐	784.0 Headache
☐	☐	☐	780.52 Loss of Sleep
☐	☐	☐	783 Loss of Weight
☐	☐	☐	799.2 Nervousness
☐	☐	☐	729.8 Neuralgia
☐	☐	☐	780.8 Sweats
☐	☐	☐	786.07 Wheezing
☐	☐	☐	311 Depression

Never	Previously	Presently	**Gastro-Intestinal**
☐	☐	☐	787.3 Belching/Gas
☐	☐	☐	789.0 Abdominal Pain
☐	☐	☐	564.0 Constipation
☐	☐	☐	787.91 Diarrhea
☐	☐	☐	783.6 Excessive Eating
☐	☐	☐	575.9 Gall Bladder
☐	☐	☐	455 Hemorrhoids
☐	☐	☐	782.4 Jaundice
☐	☐	☐	794.8 Liver Trouble
☐	☐	☐	787.02 Nausea
☐	☐	☐	536.8 Stomach Pain
☐	☐	☐	783.0 Poor Appetite
☐	☐	☐	536.8 Poor Digestion
☐	☐	☐	787.03 Vomiting
☐	☐	☐	578.0 Vomiting Blood
☐	☐	☐	783.5 Excessive Thirst
☐	☐	☐	536.8 Indigestion
☐	☐	☐	569.3 Rectal Bleeding

Never	Previously	Presently	**Eye/Ear Noise/Throat**
☐	☐	☐	493.9 Asthma
☐	☐	☐	378.9 Crossed Eyes
☐	☐	☐	389.9 Deafness
☐	☐	☐	388.70 Earache
☐	☐	☐	388.60 Ear Discharge
☐	☐	☐	388.30 Ear Noises
☐	☐	☐	240.9 Enlarged Thyroid
☐	☐	☐	460 Frequent Colds
☐	☐	☐	477 Hay Fever
☐	☐	☐	784.49 Hoarseness
☐	☐	☐	478.1 Nasal Obstruction
☐	☐	☐	784.7 Nosebleeds
☐	☐	☐	379.91 Pain in Eyes
☐	☐	☐	368.9 Poor Vision
☐	☐	☐	461.9 Sinusitis
☐	☐	☐	462 Sore Throat
☐	☐	☐	463 Tonsillitis
☐	☐	☐	786.2 Persistent Cough
☐	☐	☐	787.2 Difficulty Swallowing
☐	☐	☐	523.8 Bleeding Gums

Never	Previously	Presently	**Respiratory**
☐	☐	☐	786.50 Chest Pain
☐	☐	☐	786.2 Chronic Cough
☐	☐	☐	786.09 Difficulty Breathing
☐	☐	☐	786.3 Spitting Blood
☐	☐	☐	786.4 Spitting Phlegm

Never	Previously	Presently	**Genito-Urinary**
☐	☐	☐	788.36 Bed Wetting
☐	☐	☐	599.7 Blood in Urine
☐	☐	☐	788.4 Frequent Urination
☐	☐	☐	788.3 Lack of Bladder Control
☐	☐	☐	590.9 Kidney Infection
☐	☐	☐	788.1 Painful Urination
☐	☐	☐	601.9 Prostate Trouble

Never	Previously	Presently	**Muscle/Joints/ Bones**
☐	☐	☐	724.5 Backache
☐	☐	☐	719.7 Foot Trouble
☐	☐	☐	550 Hernia
☐	☐	☐	719.1 Pain between Shoulders
☐	☐	☐	724.6 Painful Tail Bone
☐	☐	☐	723.9 Stiff Neck
☐	☐	☐	781.9 Spinal Curvature
☐	☐	☐	719.0 Swollen Joints
☐	☐	☐	781.0 Tremors/ Twitching
☐	☐	☐	782 Arm Trouble

Never	Previously	Presently	**Cardio-Vascular**
☐	☐	☐	401.9 High Blood Pressure
☐	☐	☐	458.9 Low Blood Pressure
☐	☐	☐	786.51 Pain Over Heart
☐	☐	☐	785.9 Poor Circulation
☐	☐	☐	438 Previous Heart Trouble
☐	☐	☐	785.0 Rapid Heart
☐	☐	☐	427.89 Slow Heart
☐	☐	☐	436 Stroke
☐	☐	☐	719.7 Swelling Ankles
☐	☐	☐	454 Varicose Veins

Never	Previously	Presently	**Skin or Allergies**
☐	☐	☐	680.9 Boils
☐	☐	☐	924.9 Bruising Easily
☐	☐	☐	701.1 Dryness
☐	☐	☐	691.8 Eczema
☐	☐	☐	708.9 Hives or Allergy
☐	☐	☐	698.9 Itching
☐	☐	☐	782.0 Sensitive Skin
☐	☐	☐	782.1 Skin Eruptions

Never	Previously	Presently	**For Woman ONLY**
☐	☐	☐	625.3 Cramps or Backaches
☐	☐	☐	626.2 Excessive Flow
☐	☐	☐	627.2 Hot Flashes
☐	☐	☐	626.4 Irregular Cycle
☐	☐	☐	634.9 Miscarriage
☐	☐	☐	625.3 Painful Periods
☐	☐	☐	623.5 Vaginal Discharge
☐	☐	☐	611.79 Lump in Breast
☐ Yes ☐ No			Pregnant at this time?
☐ Yes ☐ No			Have you had a mammogram?

All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collections become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat me as deemed appropriate with the use of natural chiropractic methods, and I give authority for these procedures to be performed. I am the responsible party for payment of any treatment received or incurred during the visit. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis. The purpose of this doctor is to facilitate healing to the body by supporting its normal physiology through chiropractic, functional medicine, applied kinesiology, or nutrition.

Patient's/Guardian's Signature X: ____ Date: ____________________

NOTICE *of* PRIVACY PRACTICE

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR OFFICE.

This Notice of Privacy Practice describes how
North Georgia Center for the Healing Arts
May use and disclose your protected health information to carry out treatment, payment or heath care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

North Georgia Center for the Healing Arts
And all clinic personnel are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by contacting our office, via phone or e-mail and requesting that a revised copy be sent to you in the mail or asking for one at the time of your nest appointment.

1. **USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATOION**
   Your protected health information may be used and disclosed by your physician, our office personnel and other outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.
   Following are examples of the types of uses and disclosures of your protected health information that **North Georgia Center for the Healing Arts** is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.
   TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and as related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to the primary care physician that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., as specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.
   PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance play may undertaker before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a diagnostic test, such as an MRI, may require that your relevant protected health care information be disclosed to the health plan to obtain approval for the MRI to be performed.
   HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of student interns, Professional Applied Kinesiology students, Functional Neurology, licensing, and conducting or arranging for other business activities.
   We will share your protected health information with third party "business associates" that preform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
   We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our office to request that these materials not be sent to you.
   We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for future appointments and or concerns regarding your care

   REQUIRED BY LAW: WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO THE EXTENT THAT THE USE OR DISCLOSURE IS REQUIRED BY LAW. THE USE OR DISCLOSURE WILL BE MADE IN COMPLIANCE WITH THE LAW AND WILL BE LIMITED TO THE RELEVANT REQUIREMENTS OF THE LAW. YOU WILL BE NOTIFIED, IF REQUIRED BY LAW, OF ANY SUCH USES OR DISCLOSURES.

PUBLIC HEALTH: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR PUBLIC HEALTH ACTIVITIES AND PURPOSES TO PUBLIC HEALTH ATHORITY THAT IS PREMITTED BY LAW TO COLLECT OR RECEIVE THE INFORMATION. FOR EXAMPLE, A DISCLOSURE MAY BE MADE FOR THE PURPOSE OF PREVENTING OR CONTROLLING DISEASE, INJURY OR DISABILITY.

COMMUNICABLE DISEASES: WE MAY DISCLOSE YOUR PROTECTED INFORMATION, IF ATHORIZED BY LAW, TO A PERSON WHO MAY HAVE BEEN EXPOSED TO A COMMUNICABLE DISEASE OR MAY OTHERWISE BE AT RISK OF CONTRACTING OR SPREADING THE DISEASE OR CONTITION.

HEALTH OVERSIGHT: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO A HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW, SUCH AS AUDITS, INVESTIGATIONS, AND INSPECTIONS. OVERSIGHT AGENCIES SEEKING THIS INFORMATION INCLUDE GOVERNMENT BENEFIT PROGRAMS, OTHER GOVERNMENT REGULATORY PROGRAMS AND CIVIL RIGHTS LAWS.

ABUSE OR NEGLECT: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMAITON TO A PUBLIC HEALTH AUTHORITY THAT IS AUTHORIZED BY LAW TO RECEIVE REPORTS OF CHILD ABUSE OR NEGLECT OR ELDERLY ABUSE OR NEGLECT. IN ADDITION, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION IF WE BELIEVE THAT YOU HAVE BEEN A VICTIM OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE TO THE GOVERNMENTAL ENTITY OR AGENCY AUTHORIZED TO RECEIVE SUCH INFORMATION. IN THIS CASE, THE DISCLOSURE WILL BE MADE CONSISTENT WITH THE REQUIREMENTS OF APPLICABLE FEDERAL AND STATE LAW.

FOOD AND DRUG ADMINISTRATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A PERSON OR COMPANY REQUIRED BY THE FOOD AND DRUG ADMINISTRATION FOR THE PURPOSE OF QUALITY, SAFETY, OR EFFECTIVENESS OF FDA-REGULATED PRODUCTS OR ACTIVITIES INCLUDING, TO REPORT ADVERSE EVENTS, PRODUCT DEFECTS OR PROBLEMS, BIOLOGIC PRODUCT DEVIATIONS, TO TRACK PRODUCTS; TO ENABLE PRODICT RECALLS; TO MAKE REPAIRS OR REPLACEMENTS, OR TO CONDUCT POST MARKETING SURVEILLANCE, AS REQUIRED.

LEGAL PROCEEDINGS: WE MAY DISCLOSE PROTECTED HEALTH INFORMAITON IN THE COURSE OF ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING, IN RESPONSE TO AN ORDER OF A COURT OR ADMINISTRATIVE TRIBUNAL (TO THE EXTENT SUCH DISCLOSURE IS EXPRESSLY AUTHORIZED), OR IN CERTAIN CONDITIONS IN RESPONSE TO A SUBPOENA, DISCOVERY REQUEST OR OTHER LAWFUL PROCESS.

LAW ENFORCEMENT: WE MAY ALSO DISCLOSE PROTECTD HEALTH INFORMATON, SO LONG AS APPLICABLE LEGAL, REQUIREMENTS ARE MET, FOR LAY ENFORCEMENT PURPOSES. THESE LAW ENFORCEMENT PURPOSES INCLUDE (1) LEGAL ROCESSES AND OTHERWISE REQUIRED BY LAW, (2) LIMITED INFORMATION REQUESTS FOR IDENTIFICATION AND LOCATION PURPOSES, (3) PERTAINING TO VICTIMS OF A CRIME, (4) SUSPICION THAT DEATH HAS OCCURRED AS A RESULT OF CRIMINAL CONDUCT, (5) IN THE EVENT THAT A CRIME OCCURS ON THE PREMISES OF OUR PRACTICE, AND (6) MEDICAL EMERGENCY (NOT ON OUR PRACTICE'S PREMISES) AND IT IS LIKELY THAT A CRIME HAS OCCURRED.

CORNOERS, FUNERAL DIRECTORS, AND ORGAN DONATION: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO CORONER OR MEDICAL EXAMINER FOR IDENTIFICATION PURPOSES, DETERMINING CAUSE OF DEATH OR FOR THE CORONER OR MEDICAL EXAMINER TO PREFORM OTHER DUTIES AUTHORIZED BY LAW. WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION TO A FUNERAL DIRECTOR, AS AUTHORIZED BY LAY, IN ORDER TO PREMIT THE FUNERAL DIRECTOR TO CARRY OUT THEIR DUTIES. WE MAY DISCLOSE SUCH INFORMATION IN REASONABLE ANTICIPATION OF DEATH. PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED FOR CADAVERIC ORGAN, EYE OR TISSUE DONATION PURPOSES.

RESEARCH: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO RESEARCHERS WHEN THEIR RESEARCH HAS BEEN APPROVED BY AN INSTITUTIONAL REVIEW BOARD THAT HAS REVEIWED THT RESEARCH PREPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION.

CRIMINAL ACTICITY: CONSISTENT WITH APPLICABLE FEDERAL AND STATE LAW, WE MAY DISCLOSE YOUR PROCTED HEALTH INFORMATION, IF WE BELIEVE THAT THE USE OR DISCLOSURE IS NECESSARY TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT TO THE HEALTH OR SAFETY OF A PERSON OR THE PUBLIC. WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION IF IT IS NECESSARY FOR LAW ENFORCEMENT AUTHORITIES TO IDENTIFT OR APPREHEND AN INDIVIDUAL.

MILITARY ACTIVITY AND NATIONAL SECURITY: WHEN THE APPROPRIATE CONDITIONS APPLY, WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION OF INDICIDUALS WHO ARE ARMED FORCES PERSONNEL (1) FOR ACTICITIES DEEMED NECESSART BY APPROPRIATE MILITARY COMMAND AUTHORITES; (2) FOR THE PURPOSE OF A DETERMINATION BY THE DEPARTMENT OF VETERANS AFFAIRS OF YOUR ELIGIBILITY FOR BENEFITS, OR (3) TO FORGEIN MILITARY AUTHORITY IF YOU ARE A MEMBER OF THAT FOREIGN MILITARTY SERVICE. WE MAY ALSO DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO AUTHORIZED FEDERAL OFFICIALS FOR CONDUCTING NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, INCLUDING FOR THE PROVISION OF PROTECTIVE SERVICES TO THE PRESIDENT OR OTHER LEGALLY AUTHORIZED.

WORKERS' COMPENSATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION AS AUTHORIZED TO COMPLY WITH WORKERS' COMPENSATION LAWS AND OTHER SIMILAR LEGALLY-ESTABLISHED PROGRAMS.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made ONLY with written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, use professional judgement to determine whether the disclosure is in your best interest.

OTHER INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE: UNLESS YOU OBJECT, WE MAY DISCLOSE TO A MEMBER OF YOUR FAMILY, A RELATICE, A CLOSE FRIEND OR ANY OTHER PERSON YOU IDENTIFY, YOUR PROTECTED HEALTH INFORMATION THAT DIRECTLY RELATES TO THAT PERSON'S INVOLVEMENT IN YOUR HEALTH CARE. IF YOU ARE UNABLE TO AGREE OR OBJECT TO SUCH A DISCLOSURE, WE MAY DISCLOSE SUCH INFORMATION AS NECESSARY IF WE DETERMINE THAT IT IS IN YOUR BEST INTEREST BASED IN OUR PROFESSIONAL JUDGEMENT. WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMAITON TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATICE OR ANY OTHER PERSON THAT IS RESPONSIBLE FOR YOUR CARE OF YOUR LOCATION, GENERAL CONDITION OR DEATH. FINALLY, WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO AN AUTHORIZED PUBLIC OR PRIVATE ENTITY TO ASSIST IN DISASTER RELIEF EFFORTS AND TO COORDINATE USES AND DISCLOSURES TO FAMILY OR OTHER INDIVIDUALS INVOLVED IN YOUR HEALTH CARE.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our office if you have questions about access to your medical records.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. This means you may ask us not to use or disclose any part of your protected health information of the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATICE MEANS OR AT AN ALTERNATIVE LOCATION: We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to haw payment will be handled or specifications of an alternative address or other method of contact. We will not request an explanation form you as to the basis for the request. Please make this request in writing to our office.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with is and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical records.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVEMADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMAITON. This right applies to disclosures for purposed other than treatment, payment or health care operations as described in this Notice of Privacy Practice. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposed, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding this disclosure that occurs after July 10, 2017. The right to receive this information is subject to certain exceptions, restrictions and limitations.

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, upon request, even if you have agreed to accept this notice.

3. COMPLAINTS

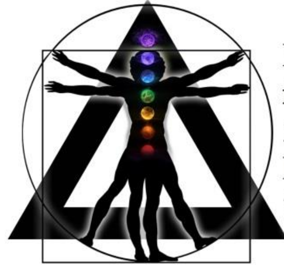
You may complain to us or use the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint.

You may contact our office at 706-946-5433 for further information about the complaint process.

This notice was published and becomes effective on July 10, 2017.

Print Name: ____

Signature: ____ Date: ____



North Georgia Center
for the Healing Arts
21 High Park Dr. St. 8
Blue Ridge, GA 30513
706-946-5433

Kindly give a 24 hour notice if you are unable to keep your scheduled appointment time.

Missed Appointment Policy

It is the policy of North Georgia Center of the Healing Arts to ask for a 24 hour advance notice for all appointment cancellations to allow the center to maximize availability for their patients. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments:

First Missed Appointment

A courtesy call will be sent to the patient of missed appointment and a review of centers policy regarding missed appointments.

Second Missed Appointment

A call will be sent to the patient of the missed appointment, a bill for the missed appointment a charge of $55.00. The missed appointment fee must be paid prior to future office visits.

Pricing

Office visits will be based upon time spent. These visits will be 1 (one) hour for new patients and 60, 40 or 20 minutes for existing patients.

60 Minutes New Patient Sessions are $195.00

60 Minutes Existing Patient Sessions are $175.00

20 Minutes Existing Patient Sessions are $65.00

***Important* North Georgia Center for the Healing Arts DOES NOT accept insurance at this time. North Georgia Center for the Healing Arts DOES NOT bill insurance of any kind for any reason this includes but not limited to Medicare, Medicaid, BSBS, Aetna, any and all private 3rd party insurance etc., we do not handle personal injury claims or workers compensation. We do however accept certain Health Savings Cards.**

*If you arrive late for your appointment, it may take away from your session time, not the patient who is scheduled after you.

Schedule Changes

We understand life happens and things may come up requiring you to have to reschedule your appointment, this is not a problem, however, if you have an appointment and you do not show or call you may be assessed a fee for the visit. A 24 hour notice is not required but would be greatly appreciated.

Additional Fees:

The office will assess a $3.00 fee for all Debit/Credit card transactions. Excluding supplements.

I understand and agree to these terms and I am also aware pricing is subject to change at any time.

Print Name: ______________________________ Signature: ____________________________

Date: _______________________