NMR
NATURAL MEDICINE REHABILITATION & PAIN MANAGEMENT

Date: _____

A Premier Orthopedic Rehabilitation Institute

First Name: _____ **Last Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SS#: _____ **Gender:** Male Female **Language**: English Spanish Other:_____

Marital Status: Single Married Widowed Divorced Separated **Spouse Name**: _____
Race: Caucasian African Am. Hispanic Asian Middle Eastern Pacific Is. Native Am.

Home Phone: _____ **Work/Cell Phone:** _____

Email Address: _____ **Contact Pref.:** Home Cell

Occupation: _____ **Employer:** _____

Emp. Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Reason for today's visit: _____

Have you had: ▪ X-Ray ▪ MRI ▪ CT **If so, at which facility?** _____

How did you hear about our office? ▪ Internet/Google ▪ Dr. _____ ▪ Friend: _____

Insurance Information: ___**No Fault** ___**Slip & Fall** ___**IEM** ___**Private Insurance** ___**Other**

Primary Insurance Company: _____ **Group, Plan or Policy #:**_____
Policy owner is your: ▪ Self ▪ Spouse ▪ Parent ▪ Other: _____
Policy Owner's Name & DOB: _____

Secondary insurance: _____ **Group, Plan or Policy #:**_____
Policy owner is your: ▪ Self ▪ Spouse ▪ Parent ▪ Other: _____
Policy owner's name & DOB: _____

No-Fault Insurance Case:
Insurance Company Name:_____**Date of Accident:** _____
Address: _____
Claim #: _____ **Adjuster's Name:** _____
Policy #: _____ **Policy Holder's Name:** _____

Worker's Compensation Case:
Insurance Carrier: _____ **Date of Injury:** _____
Address: _____
Claim #: _____ **Adjuster's Name:** _____
Phone#: _____
Where did the injury occur? _____
Are you working? _____ **Full-time:** _____ **Part-time:**_____
If no, when did you stop working? _____ **When did you begin work?** _____

Attorney's Information:
Attorney's Name: _____ **Phone #:** _____
Address: _____

Family Medical History (include relationship to you on the line provided):

□ Cancer _____ □ Diabetes _____ □ Heart Disease _____ □ Depression _____
□ Seizure _____ □ Hepatitis _____ □ Thyroid Disease _____ □ Alcoholism _____
□ High Blood Pressure _____ □ High Cholesterol _____ □ Stroke _____
□ Other: _____

CONSTITUTIONAL
- Fever
- Chills
- Change in appetite
- Weight loss
- Weight gain
- General fatigue

EYES
- Loss of vision
- Altered vision
- Chronic dry eyes
- Eye pain/discomfort
- Abnormal discharge
- Photophobia
- "Puffy" eyes

ENMT
- Frequent earaches
- Abnormal discharge
- Tinnitus
- Loss of hearing
- Frequent colds/ sinusitis
- Persistent congestion
- Frequent nosebleeds
- Gingivitis/ Periodontal disease
- Dysphagia
- Hoarseness
- Frequent/ recurrent sore throat
- Dry mouth

RESPIRATORY
- Sleep apnea
- Disruptive snoring
- Persistent, dry cough
- Coughing up blood
- Dyspnea
- Non - cardiac chest pain
- Wheezing
- Excessive sputum
- Pulmonary edema
- Asthma
- Tuberculosis
- Emphysema

HEMATOLOGIC/LYMPHATIC
- Bleeding disorder
- Abnormal bruising

GASTROINTESTINAL
- Indigestion/ Excessive gas
- Irritable Bowel Syndrome
- Crohn's Disease
- Ulcerative Colitis
- Celiac Disease
- GERD/ heartburn
- Frequent nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Abnormal stools
- Swelling, or bloating in the abdominal area
- Hepatomegaly
- Hemorrhoids

CARDIOVASCULAR
- Heart attack
- Stroke
- Abnormal blood pressure
- Angina
- Cardiac arrhythmia
- Lightheadedness
- Cardiac palpitations
- Swelling of hands & feet
- Difficulty breathing while lying down
- Peripheral Artery Disease
- Cyanosis
- Diaphoresis
- Tachycardia
- Bradycardia
- Pericardial effusion

SKIN
- Suspicious lesions
- Excessive perspiration
- Poor/slow wound healing
- Dry skin
- Persistent itch
- Rash
- Abnormal coloring
- Eczema
- Psoriasis
- Acne
- Abnormal change in appearance of nails or hair
- Peeling of the skin

ENDOCRINE/METABOLIC
- Intolerance to hot/cold
- Excessive thirst/hunger
- Excessive urination
- Autoimmune Disease
- Lupus SLE
- Rheumatoid Arthritis
- Diabetes, Type: _____
- Metabolic Syndrome
- Hypo/ Hyperthyroidism
- Weight fluctuations
- Eating disorder

NEUROLOGIC/ MOOD
- Depression
- Anxiety
- Bipolar disorder
- Suicidal thoughts
- Compulsions
- Hallucinations
- Headaches
- Disruptive migraines
- ADD/ ADHD
- Memory loss
- Parkinson's Disease
- Multiple Sclerosis
- Poor balance
- Difficulty speaking
- Difficulty concentrating
- Dyspraxia
- Numbness, or tingling
- Brief, unexplained paralysis
- Syncopal episodes
- Epilepsy, or other seizures
- Tremors
- Dizziness/vertigo
- Excessive, daytime fatigue

MALIGNANCIES
- Lung cancer
- Breast cancer
- Colon cancer
- Ovarian cancer
- Prostate cancer
- Skin cancer
- Pancreatic cancer
- Lymphoma
- Leukemia
- Brain cancer
- Other: _____

MUSCULOSKELETAL
- Osteoporosis/ Osteopenia
- Scoliosis
- Muscle cramps
- Joint stiffness
- Muscle weakness
- Muscle Aches
- Loss of strength

LOCATION OF PAIN
For each body location, circle all that apply.
(R-right, L-left, S-swelling)

Head	R	L	S
Face	R	L	S
Jaw	R	L	S
Neck	R	L	S
Upper back	R	L	S
Shoulder	R	L	S
Upper arm	R	L	S
Abdominal	R	L	S
Mid back	R	L	S
Elbow	R	L	S
Forearm	R	L	S
Wrist	R	L	S
Pelvic	R	L	S
Hand	R	L	S
Finger	R	L	S
Low back	R	L	S
Hip	R	L	S
Thigh	R	L	S
Knee	R	L	S
Lower leg	R	L	S
Ankle	R	L	S
Foot	R	L	S
Heel	R	L	S
Toe	R	L	S
Other_____			

Height: _____
Weight: _____

How long have you had pain? _____**months** _____**years**

Describe the quality of the pain: Knife Like Burning Electric Shock Throbbing Dull Ache

Describe the duration of the pain: Constant Comes & Goes Always present but gets worse at times

Describe the intensity of the pain: Mild Discomforting Distressing Horrible Excruciating

Pick a number for your pain: Least 1 2 3 4 5 6 7 8 9 10 Worst

What makes the pain worse: Sitting Walking Damp Weather Other: _____

What makes the pain better: Rest Hot Shower Other: _____

What treatments have you received: Physical Therapy Injections None Other (specify) _____

What medications do you take for pain? _____

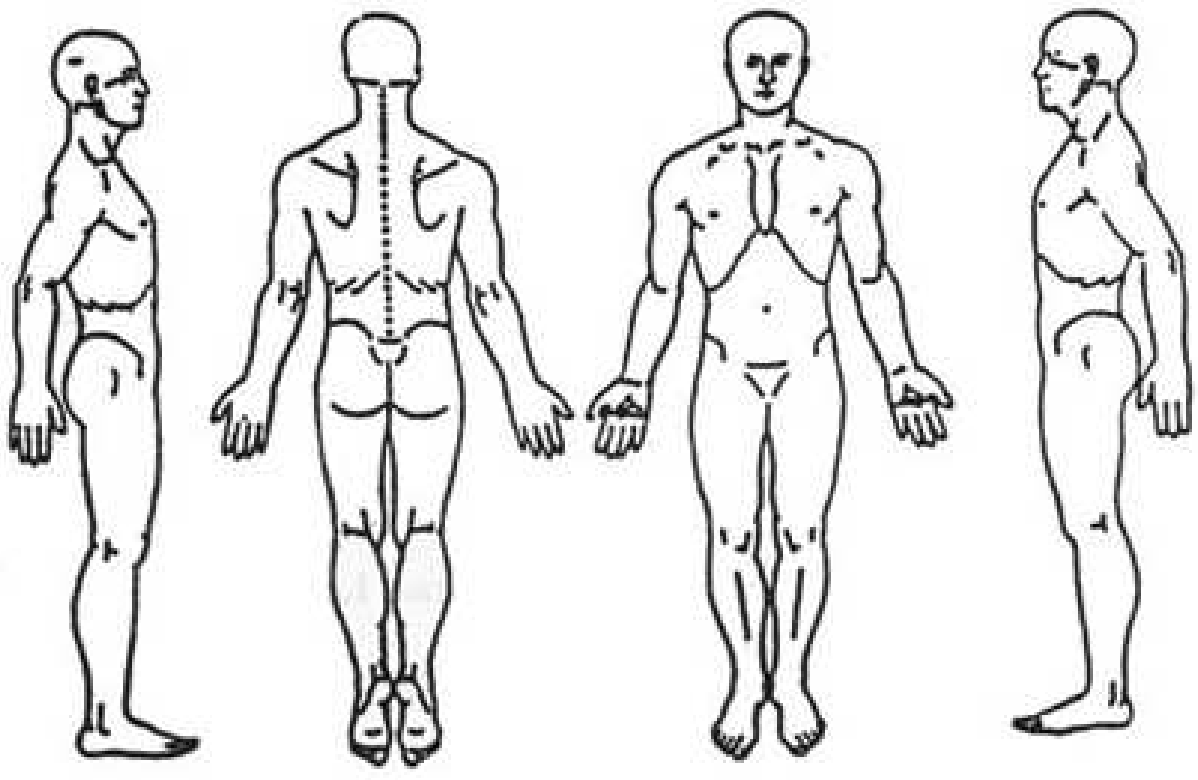
Do you take Aspirin/Baby Aspirin or Blood Thinning Medications? Yes No

How do you sleep at night? Poor Fair Normal

Have you had to cut down on normal activities because of our pain? Yes No

If yes, how much? Mildly Moderately Severely

On the drawing below please shade in the areas in which you are experiencing pain:



Right Side Backside Front Left Side

List all prior surgeries (minor & major) and hospitalizations:

Date		Date	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all current medications with dosage and frequency (include daily vitamins and over the counter medication):

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____ **City & State:** _____ **Phone #:** _____

List all discontinued medications with dosage and the reason you stopped taking them:

Name	Dosage	D/C
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergies (include allergies to medication, food, and environmental) and their reactions:

Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? Yes No **How many packs per day?** _____ **Do you drink alcohol?** Yes No Socially

Pain Management Narcotic Administration Contract

This agreement is between patient and the pain management physician. It is agreed that narcotic medications will be given by the physicians ONLY if the following terms are met:

1. Pain Management Physician discusses the uses of narcotic medications with the patient, including the issues of appropriate realistic goals for pain relief, proper methods of taking the medications, risks of side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal problems due to these medications.
2. The patient has a chance to ask questions regarding the use of narcotic medications.
3. By signing a special consent form for chronic narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including all the side effects, and is agreeable to start this treatment under the terms set by Pain Management Physician.
4. Pain Management Physician should be the one and only source of narcotic medications unless written permission is given by Pain Management Physician for the patient to get narcotic prescriptions from another physician.
5. Only one pharmacy will be used for filling narcotic prescriptions. The name, address and telephone number will be given to Pain Management Physician.
6. If it is found that the patient received prescriptions for narcotic medications from a source other than a Pain Management Physician without written permission, Pain Management Physician may void this agreement and discontinue any prescription of narcotic medications to the patient.
7. The patient agrees to have urine tests (screening for medications) done randomly at the physician's request.
8. The patient must agree to allow the Pain Management Physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
9. The patient understands that Pain Management Physician will not replace any lost or inaccessible narcotic prescriptions or narcotic medications for ANY REASON.
10. The patient must take the narcotic medications exactly as instructed by the Pain Management Physician.
11. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.
12. If the patient demonstrates unacceptable behavior patterns, the Pain Management Physician may discontinue prescribing the narcotic medications for the patient.
13. The patient must keep all regular follow up appointments as recommended by the Pain Management Physician. Failure to comply may cause discontinuation of narcotic prescriptions.
14. All triplicate prescriptions must be picked up by the patient themselves. If the patient is too debilitated or sick, an exception may be allowed.
15. No triplicate (narcotic) prescriptions will be refilled on weekends or over the phone. Narcotic prescriptions cannot be refilled over the phone – refills will only be issued at the time of your follow up visit. If your prescription does not last until your next visit, that indicates a problem. Please schedule an appointment at your earliest convenience in order to discuss the reasons why you ran out of medication and whether we can refill your narcotic prescription.
16. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of Rehabilitation, return to work, maintenance of a job, etc.
17. The patient understands that narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
18. The patient certifies or agrees to the following:
    a. That he/she is not currently abusing illicit or prescription drugs, and that he/she is not undergoing treatment for substance dependence or abuse.
    b. That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers).
    c. That she is not pregnant and that she will use appropriate contraception during her course of treatment.
    d. Sharing your narcotics is STRICTLY prohibited. Any sharing will result in the immediate cancellation of your prescription refills.
19. Evidence of medication hoarding, increasing the amount of medication without communication to your Pain Management Physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of the medication despite significant side effects, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with the drug labeling) during narcotic analgesic treatment or other inacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract.

Patient Signature: _____ **Date:** _____

Authorization for Release of Medical Records

I hereby authorize Natural Medicine, Rehabilitation, & Pain Management ("NMRPM") to release or request from other physicians or hospitals, any and all information which they possess or require relating to my examinations and illness, which may be part of the medical record, including psychiatric/psychological, alcohol, drug abuse, AIDS, ARC, or HIV related diagnosis, treatments and rehabilitation for the following period:

Primary Care Physician

Full Name: _____ Specialty: _____

Address: _____

Phone # : _____ Fax #: _____

List All Currently Treating Physicians:

Full Name: _____ Specialty: _____

Address: _____

Phone # : _____ Fax #: _____

Full Name: _____ Specialty: _____

Address: _____

Phone # : _____ Fax #: _____

Full Name: _____ Specialty: _____

Address: _____

Phone # : _____ Fax #: _____

Previous Pain Management Physician:

Full Name: _____ Specialty: _____

Address: _____

Phone # : _____ Fax #: _____

Information is being released or requested for the following reasons:

To a Physician for continued medical care
Insurance
Attorney
Other: _____

Patient Signature: _____ **Date:** _____

Financial Policy

In consideration of Natural Medicine, Rehabilitation & Pain Management ("NMRPM") undertaking to provide services to me, I hereby agree that I am responsible to NMR for payment of all such services.

I understand that some, or perhaps even all, of the services provided by NMRPM may be considered uncovered services, and therefore not payable by my insurance company. In the event that I reach agreement with NMRPM's staff on a weekly patient cost obligation relating to services rendered, I shall pay such weekly patient cost obligation.

I hereby absolutely authorize NMRPM to apply for benefits on my behalf for services rendered to me and request that payment be made by my insurance company and that payments be sent directly to NMRPM. If I have active and valid insurance coverage, I have supplied NMRPM with the up-to-date and correct insurance identification card(s). In the event that payment of insurance benefits for services provided by NMRPM is made to me directly by my insurance company, I hereby agree that within thirty (30) days of receipt, I shall endorse the insurance company's check or other instrument to the payment of NMRPM and deliver it to NMRPM, along with any accompanying explanation of benefits ("EOB"). I further authorize NMRPM to charge any credit card that I have provided the full amount of any insurance benefits received by me directly, in the event I fail to endorse and deliver the endorsed insurance company's check or other instrument, along with the EOB, to NMRPM within thirty (30) days of receipt; and in each such event acknowledge that NMRPM will impose a surcharge of Five Percent (5%) of the amount of such insurance benefits to cover NMRPM's administrative costs. I hereby further irrevocably assign my rights to benefits under my contract of insurance or other third party payment to NMRPM, as well as all benefits payable to me under my insurance policy and health benefits plan.

I hereby authorize NMRPM to release any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I may revoke this authorization at any time in writing.

I understand and agree that NMRPM may charge the credit card that I've provided for the following: (i) Fifty and 00/100 Dollars ($50.00) for any missed visit for specialty services, including acupuncture, aesthetics, clinical nutrition and massage, should I fail to provide notice of cancellation at least twenty-four (24) hours in advance of the visit, and (ii) One Hundred and 00/100 Dollars ($100.00) in the event that I fail to return to NMRPM within thirty (30) days, any original x-rays which I received, and understand that such charges are not covered by my insurance company. In the event I do not have a credit card on file with NMRPM, I am aware I will be billed directly for such charges.

I certify that I have read the above information, or that the information has been read or translated to me, and that I understand my rights and obligations as a patient of NMRPM under this agreement.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please print)

Assignment of Benefits Form

Automobile Accident: **Date of Accident: _____**

I assign to Natural Medicine, Rehabilitation, & Pain Management ("NMRPM") my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above.

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose filing said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at all deposition and the appearance at any arbitration or trial if my attendance is required.

Workmen's Compensation: **Date of Injury: _____**

For consideration received, I, assign to NMRPM my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignors or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above.

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose of filling said lawsuit; individually, in the injuries arbitration with the National Arbitration Form on the bill for the assignee.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement judgment or verdict with may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient Signature	Date	Print Name
_____	_____	_____
Signature of Patient Representative	Date	Print Name
_____	_____	_____
Signature of Witness	Date	Print Name

Assignment of Benefits Limited Power of Attorney

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier I irrevocably authorize you to retain an attorney of our choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to "ERISA".

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deems invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for our medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me**. I authorize you and/or your attorney to receive from my insurer, immediately upon verbal request all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and/or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such healthcare provider(s) to release all such information to you about me, including medical reports, x-rays reports, narrative reports, and any other report or information regarding my physical condition.

Patient's Signature

Date

HIPAA 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. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use, and disclose, your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted, or required, by law. It also describes your rights 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.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare 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 medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare 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 purposes 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 the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may file a complaint with us, or to 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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

I authorize Natural Medicine, Rehabilitation & Pain Management to discuss my health care information with the individuals listed below.

Name:_____ Telephone #: _____ Relationship: _____

Name:_____ Telephone #: _____ Relationship: _____

Name:_____ Telephone #: _____ Relationship: _____

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ DOB: _____

Signature: _____ Date: _____