TO THE NEW PATIENT

Outline of Procedure for New Patients

1. **STEP ONE:**
   All new patients are requested to fill out a personal health/history questionnaire.

2. **STEP TWO:**
   Your first consultation with the doctor to discuss your health problems.

3. **STEP THREE:**
   Evaluations/Exams/Tests are done to determine care for you.

4. **STEP FOUR:**
   The doctor will advise you as to the need of additional procedures such as X-ray tests, if necessary.

5. **STEP FIVE:**
   You will be given a "***Report of Findings***" on your second scheduled visit. The doctor will inform you as to your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. **STEP SIX:**
   After you receive your report of findings, your recommended course of care will be explained to you.

7. **STEP SEVEN:**
   Visits/Adjustments will begin and continue as scheduled until maximum correction for you has been obtained, as determined by re-evaluation by the Doctor.

8. **STEP EIGHT:**
   After maximum correction, a schedule of care will be recommended.

Name _____

Date _____

On a scale of 1 (poor) to 10 (optimum), mark your current health level in these seven essential areas:

Physical Health
What is your physical condition? Are you receiving good nutrition, drinking plenty of water, getting regular exercise and enjoying the proper weight for your height?

Mental Health
Are you open to new ideas? Do you to seek out new experiences and learn new skills? What is the quality of the information and entertainment you allow into your mind?

Financial Health
Are you living within your means? Is your debt within manageable limits? Do you make charitable contributions and save for the future? Are you properly insured?

Spiritual Health
How connected do you feel to the higher power in your life? Do you enjoy a sense of purpose and peace? Do your regularly study, meditate, pray or worship?

Family Health
Are you in a loving relationship with shared values? Do you give your family time and attention? Do you have a close connection with children, parents and relatives?

Career Health
Do you like what you do for a living? Does your career reflect and advance your deepest values? Is your work meaningful and suited to your skills and interests?

Social Health
How well do you interact with others? Are you able to maintain long-term friendships? Are you comfortable in new social situations and the company of others?

Your health affects everything you do and everyone you know. We use this confidential worksheet to record a "snapshot" of your estimated overall health so we can track your progress.

WELLNESS WHEEL

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or symptom.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

If X-rays are deemed necessary for complete analysis of my health challenges, I authorize One Stop Wellness to perform or refer for such radiographic examinations.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction.

I, _____ have read and fully understand the above statements and therefore accept
(print name)
chiropractic care on this basis.

_____ _____
(Signature) *(Date)*

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Guardian Signature) *(Date)*

Pregnancy Release:

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. If pregnant, I agree to cervical x-rays with the use of filters and/or a lead apron.

Date of first day of last menstrual period: _____

Method of birth control: (circle one) abstinence/other_____

_____ _____
(Signature) *(Date)*

SAUNAS AND CONTRAINDICATIONS

Like all professional equipment, you may put yourself at risk if you do not fully understand how to use the **sauna**. Drinking an electrolyte replacement water or sports drink is strongly recommended before and after sauna use. Infrared **saunas** creating a cure for or treating any disease is neither implied nor should be inferred.

If any of the items listed below apply to you, be certain to consult with your physician before using an infrared **sauna**.

- **Medications**
- **Children**
- **The Elderly**
- **Cardiovascular Conditions**
- **Alcohol / Alcohol Abuse**
- **Chronic Conditions / Diseases Associated With Reduced Ability To Sweat Or Perspire**
- **Hemophiliacs / Individuals Prone To Bleeding**
- **Fever**
- **Insensitivity to Heat**
- **Pregnancy**
- **Menstruation**
- **Joint Injury**
- **Implants**
- **Pacemaker / Defibrillator**

Saunas & Medications
Individuals who are using prescription drugs should seek the advice of their personal physician or a pharmacist for possible changes in the drugs effect when the body is exposed to **infrared** waves or elevated body temperature. Diuretics, barbiturates and beta-blockers may impair the body's natural heat loss mechanisms. Anticholinergics such as amitryptaline may inhibit sweating and can predispose individuals to heat rash or to a lesser extent, heat stroke. Some over-the-counter drugs, such as antihistamines, may also cause the body to be more prone to heat stroke.

Saunas & Children
The core body temperature of children rises much faster than adults. This occurs due to a higher metabolic rate per body mass, limited circulatory adaptation to increased cardiac demands and the inability to regulate body temperature by sweating. When using with a child, operate at a lower temperature and for no more than 15 minutes at a time.

Saunas & The Elderly
The ability to maintain core body temperature decreases with age. This is primarily due to circulatory conditions and decreased sweat gland function. The body must be able to activate its natural cooling processes in order to maintain core body temperature. When using with the elderly, operate at a lower temperature and for no more than 15 minutes at a time.

Saunas & Cardiovascular Conditions
Individuals with cardiovascular conditions or problems (hypertension / hypo tension), congestive heart failure, impaired coronary circulation or those who are taking medications which might affect blood pressure should exercise caution when exposed to prolonged heat. Heat stress increases cardiac output and blood flow in an effort to transfer internal body heat to the outside environment via the skin (perspiration) and respiratory system. This takes place primarily due to major changes in the heart rate, which has the potential to increase by thirty (30) beats per minute for each degree increase in core body temperature.

Saunas & Alcohol / Alcohol Abuse
Contrary to popular belief, it is not advisable to attempt to "sweat out" a hangover. Alcohol intoxication decreases a person's judgment; therefore, he/she may not realize when the body has a negative reaction to high heat. Alcohol also increases the heart rate, which may be further increased by heat stress.

Saunas & Chronic Conditions / Diseases Associated With Reduced Ability To Sweat Or Perspire
Multiple Sclerosis, Central Nervous System Tumors and Diabetes with Neuropathy are conditions that are associated with impaired sweating. An individual with reduced ability to adapt to heat should consult their doctor before sauna use.

Saunas & Hemophiliacs / Individuals Prone To Bleeding
The use of infrared **saunas** should be avoided by anyone who is predisposed to bleeding.

Saunas & Fever
An individual who has a fever should not use an infrared **sauna** until the fever subsides.

Saunas & Insensitivity to Heat
An individual with insensitivity to heat should not use an infrared **sauna**.

Saunas & Pregnancy
Pregnant women should consult a physician before using an infrared **sauna**.

Saunas & Menstruation
Heating of the low back area of women during the menstrual period may temporarily increase their menstrual flow.

Saunas & Joint Injury
If you have a recent (acute) joint injury, it should not be heated for the first 48 hours after an injury or until the swollen symptoms subside. If you have a joint or joints that are chronically hot and swollen, these joints may respond poorly to vigorous heating of any kind.

Saunas & Implants
Metal pins, rods, artificial joints or any other surgical implants generally reflect infrared waves and thus are not heated by this system. Nevertheless, you should consult your physician prior to using an **infrared sauna**.

Saunas & Pacemakers / Defibrillators
The magnets used to assemble our **saunas** can interrupt the pacing and inhibit the output of pacemakers. Please discuss with your doctor the possible risks this may cause.

*In the rare event that you experience pain and/or discomfort, immediately discontinue **sauna** use.*

I have read and understand the contraindications to sauna use. I understand it is my responsibility to discuss with my medical doctor any contraindications I may have and it is my responsibility to decline use if it is not appropriate for me.

_____	_____	_____
Sign name	Print Name	Date
_____	_____	_____
Witness Sign name	Print Name	Date

Patient name: _____

Office Policies & Procedures

(Please initial each and sign at bottom)

_____Fees are payable when service is rendered unless other arrangements have been made in advance. Insurance co-payments are due at time of service. Ancillary services will be an additional fee. Fees are subject to change without notice**. Returned checks are subject to a $35 fee.**

_____I understand that if my account is overdue by 60 days One Stop Wellness may send this account to a collection agency or attorney for collection. Any/All fees including collection percentages will be added to the unpaid balance and be the sole responsibility of the undersigned. Collection fees, Attorney fees and court costs will be the sole responsibility of the undersigned. If you do not agree to the collection policy then it will be necessary to collect fees prior to services rendered.

_____I hereby acknowledge that I have received the Notice of Privacy Practices statement (version 3.1.11)

_____I understand this office offers both open and private rooms. "Open" means multiple patients may receive care in one room at the same time. In this situation, other patients may observe your care. If this presents a concern to you, please notify your doctor and we will do our best to accommodate your concerns. At any time in your care you may request to see or speak with the doctor in a private room.

_____I authorize One Stop Wellness to release any information or office records to my insurance company or lawyer.

_____I authorize the release and the payment of health benefits to One Stop Wellness and the respective doctor. This is to serve as a long term authorization.

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

_____**Appointments:** A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call 24 hours in advance to reschedule any appointments so you stay on target for wellness. It is your responsibility to get here. We will do all we can to accommodate you. **Missed appointments may incur a $25 charge, even if you are on a Pre-paid Wellness Plan!**

_____**Daily Visit Procedure:** Each time you arrive for your adjustment, sign in and have a seat in the reception room until you are directed to an adjusting room by the front desk chiropractic assistant. Each visit please remove all jewelry, empty everything from your pockets, remove belt and loosen your tie. Our open environment allows you to receive your care quickly and efficiently with minimal waiting. Should you feel the need for a private adjustment or consultation, inform our staff and we will gladly accommodate you, at no extra charge of course. In addition, please avoid wearing strong perfume or cologne to our office because many of our patients have sensitivities. Thank you.

_____**Re-examinations:** During your Initial Intensive Care you will receive Re-Exams to monitor your level of spinal correction. On this visit you will fill out a Re-exam Form and be taken to the Exam Room. All the findings from your initial visit will be retested. The Re-Exam will take approximately 30 minutes. There is an additional fee for this visit unless you are on a Prepayment Plan that is all-inclusive. The doctor will discuss your results and the plan of action with you following the re-exam. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

_____**New Patient Orientation Class:** At this important visit we will provide you with the information you need to get the best results from your care. It is our policy that you attend within the first 2 weeks of care. We recommend that you bring your spouse, a family member or friend with you so you create a support group who understands your care and keeps you focused on your desired results. Also, if you know anyone else with a health problem, or who is committed to a wellness lifestyle, our orientation program would be a great way to introduce them to our office without any obligation or financial commitment.

_____**Exercise:** Research shows that people who exercise on a spine which was injured, and improperly healed, will tend to experience more rapid deterioration of their spinal bones, disks, and nerves. However, when you do appropriate exercise in conjunction with your chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced. We recommend that you do the super-slow style of exercise, as the research is most supportive of you giving you long term benefit.

_____**Nutrition:** Good nutrition is important to maximize your health and healing capacities. One Stop Wellness offers customized clinical nutrition to help you get well and stay well. Please ask about scheduling an appointment for a nutritional consultation.

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

PATIENT (or guardian) SIGNATURE: _____ DATE: _____

Congratulations on making a choice for your wellness! Remember that your family can also enjoy the health benefits that come with a Wellness Lifestyle.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____-____-_____ Birthday: _____-_____-_____

Contact Information (Please Circle Which Number You Prefer To Be Called At)

Home: _____-_____-_____ Work: _____-_____-_____

Cell: _____-_____-_____ Cell Carrier:_____ Email:_____

Emergency Contact: _____(relationship) _____

Emergency Contact's Number: _____-_____-_____

How did you hear about us? _____

With whom do your currently live: Alone Spouse Spouse/Children Other

Smoking Status: Current Former Never

Alcohol Intake: None Casual Moderate Severe

Caffeine Intake: None < 3/day 3 to 6/day >6/day

Recreational Drugs: None Recreational User Addict

Exercise Frequency: Never Daily (3-7x/week) Weekly

Exercise Type: _____

Are you currently: In School Employed Unemployed Retired
Occupation:_____

How long have you been at your current job:_____

What is your: Height:_____ **Weight:**_____

Female Patients, to the best of your knowledge are you pregnant? Y N

Do you currently have a Primary Care Physician? Y N

Doctor's Name:_____

PATIENT HISTORY

What medications you are currently taking?

Date Started	Drug Name	Prescribed By

Please list any allergies

Allergy	Reaction

Please list any surgeries

Date (Approximate)	Surgery

Please list hospitalizations (you can exclude surgery-related if listed above)

Date (Approximate)	Reason	Hospital

Please list any major illnesses

Date (Approximate)	Illness

Please list any pertinent family history

Relationship	History	Deceased Y/N	Cause of Death

Please list your CURRENT health challenges

Problem	What you have tried?	Did it help?

Please List Your Health Goals

GOAL	What you have tried	Did it help?

To the best of my knowledge, all of the information completed above is correct.

Signature: _____ Date: _____

One Stop Wellness

Dr. Cara Iovino
785 Myrtle St.
Roswell, GA 30075
(404) 474-7446

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH OR 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 at **785 Myrtle St., Roswell, GA 30075** in person or by phone at (**404) 474-7446.**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Care in the Office We may use health information about you to provide you with chiropractic care or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be caring for you for subluxations and may need to know if you have other health problems that could complicate your care. The doctor may use your health history to decide what care is best for you. Your doctor may also consult with another doctor about your condition so the second doctor can help determine the most appropriate care for you.

Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as scheduling lab work and ordering X-rays. Family members and other health care providers may be part of your care outside this office and may require information about you that we have.

This office utilizes "open adjusting" procedures. This means multiple patients may receive care in one room at the same time. In this situation, other patients may observe your care in this office. If this presents a major concern to you, please notify your doctor and we will do our best to accommodate your concerns.

For Payment We may use and disclose health information about you so that the care and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your insurance company information about a service you received here so your insurance company will pay us or reimburse you for the service. We may also tell your insurance company about a service you are going to receive to obtain prior approval, or to determine whether your plan will cover the service.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new services will be used.

Appointment Reminders We may contact you as a reminder that you have an appointment at the office.

Cards We may also send you birthday cards, other greeting cards or letters.

Patient Testimonials We may use any patient testimonial, photos, or likenesses, that you provide or allow to be made for the purpose of sharing your results in our care.

Health Care Alternatives We may tell you about or recommend possible health care options or alternatives that may be of benefit to you.

Health-Related Products and Services We may inform you verbally, electronically, or by mail about health related products or services that may be of interest to you or information pertinent to your condition, new research, health care options, or other health related information.

Please notify us if you do not wish to be contacted for appointment reminders or birthday cards, or if you do not wish to receive communications about health care alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of health care, payment, or operations, and we may therefore be unable to bill your insurance company, thus we will have to change your account to cash paid in full at the time of service.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

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 your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during the visit or while care is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf, for example, to pick up supplies or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of care, payment, or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as health and billing records, that we use to make decisions about your care. You must submit a written request to **One Stop Wellness** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request

and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Health Record Amendment/Correction Form to **One Stop Wellness.** We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **One Stop Wellness.** It must state a time period, which may not be longer than six years and may not include dates before March 1, 2011. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for care, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request If we do agree; we will comply with your request unless the information is needed to provide you emergency care.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical Information* to **One Stop Wellness.**

Right to Request Confidential Communications You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information and/or Confidential Communication* to **One Stop Wellness.** We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice 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. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **One Stop Wellness.**

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the privacy officer at **One Stop Wellness** at **785 Myrtle St., Roswell, GA 30075** in person or by phone at **(404) 474-7446.** You will not be penalized for filing a complaint.