

WELCOME TO ADVANCED HEALTH CHIROPRACTIC

PERSONAL INJURY INFORMATION

Date of Injury:

Insurance Company (Responsible for Payment):

Insurance Company Address:

Claim Number:

Claims Representative:

Claims Representative Phone Number:

Attorney:

Attorney's Address:

Attorney's Phone Number:

PERSONAL INJURY QUESTIONNAIRE

PATIENT REGISTRATION

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F S.S. Number: _____ - _____ - _____
Address: _____ / _____ / _____ / _____
Street City State Zip Code
Phone: (Home) _____ (Cell) _____ (Work) _____ Ext. _____
Email: _____
Occupation: _____ Employer: _____
Emergency Contact: (Name) _____ (Phone Number) _____
Who may we thank for referring you to our office? _____

INSURANCE

Your Insurance Company: _____
Policy Number: _____
Agent Name: _____
Name on Policy (If Other Than Self): _____
Policy Number: _____
Responsible Party's Name: _____
Address: _____ / _____ / _____ / _____
Street City State Zip Code
Policy Holder's Name: _____
Policy Number: _____

ATTORNEY

Name: _____
Phone Number: _____
Address: _____ / _____ / _____ / _____
Street City State Zip Code
Were there any witnesses? ☐ Yes ☐ No If so, name(s): _____

NATURE OF ACCIDENT

Date of Accident: _____
Time of Day: _____
You Were: ☐ Driver ☐ Front Passenger ☐ Rear Passenger
Number of people in your vehicle: _____
Were you wearing seat belts? _____
What direction were you headed? ☐ North ☐ South ☐ East ☐ West
On Name of Street: _____
What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West
On Name of Street: _____
Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
Approximate speed of your car: _____ mph
Other car's speed: _____ mph
Were you knocked unconscious? ☐ Yes ☐ No
If yes, for how long? _____
Were Police notified? ☐ Yes ☐ No
In your own words, describe the accident: _____

SYMPTOMS RELATED TO ACCIDENT

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No

If yes, please describe in detail:

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

What are your PRESENT complaints and symptoms? _____

Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever been involved in an accident before? ☐ Yes ☐ No

If yes, please describe; include date(s) and type(s), as well as injury(ies) received: _____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If so, please list doctor's name and address: _____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

Check symptoms you have noticed since the accident:

- | | | | | |
|--------------------------------------|---------------------------------------|--|--|---|
| ☐ Headache | ☐ Irritability | ☐ Numbness in Toes | ☐ Fainting | ☐ Sleeping Problems |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Shortness of Breath | ☐ Buzzing in Ears | ☐ Head Seems Heavy |
| ☐ Neck Stiff | ☐ Dizziness | ☐ Loss of Balance | ☐ Stomach Upset | ☐ Pins & Needles in Arms |
| ☐ Back Pain | ☐ Face Flushed | ☐ Depression | ☐ Constipation | ☐ Pins & Needles in Legs |
| ☐ Fatigue | ☐ Feet Cold | ☐ Light Bothers Eyes | ☐ Loss of Smell | ☐ Cold Sweats |
| ☐ Nervousness | ☐ Hands Cold | ☐ Loss of Memory | ☐ Loss of Taste | ☐ Numbness in Fingers |
| ☐ Tension | ☐ Ears Ring | ☐ Diarrhea | ☐ Fever | |

Symptoms other than above: _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, please complete the following:

Last Day Worked: _____

Type of Employment: _____

Present Salary: _____

Are you being compensated for lost time from work? ☐ Yes ☐ No

If yes, please state type of compensation you are receiving: _____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

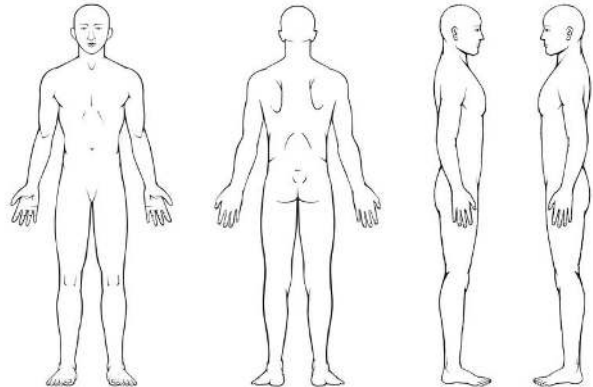
If yes, please describe in detail:

Other Pertinent Information: _____

CONDITION

1. Area of Complaint: _____
When did your symptoms start? _____
How did your symptoms begin? _____

**Mark or shade in where you have pain
or other symptoms on the drawings to the right:**



2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

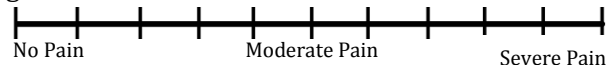
(Check all that apply)

- ☐ Sharp ☐ Shooting
☐ Dull Ache ☐ Burning
☐ Numb ☐ Tingling
☐ Other: _____

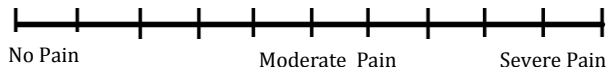
4. How are your symptoms changing?

- ☐ Getting Better ☐ Not Changing ☐ Getting Worse

5. Circle the average intensity of your symptoms:



6. Circle in your symptoms at their worst:



7. Who have you seen for your symptoms?

- ☐ No One ☐ Medical Doctor ☐ Physical Therapist ☐ Other Chiropractor
☐ Other: _____

8. Have you had similar symptoms in the past? ☐ Yes ☐ No If so, when? _____

9. What makes your symptoms feel better? _____

10. What makes your symptoms feel worse? _____

11. What activity/activities does this problem prevent you from doing, either partially or totally, that you would really like to be doing again? _____

12. Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

13. Do you suffer from any conditions other than that which you are now consulting us? _____

14. Have you had any fevers lately? _____ If so, when? _____

15. Have you had any unusual shortness of breath? _____ If so, when? _____

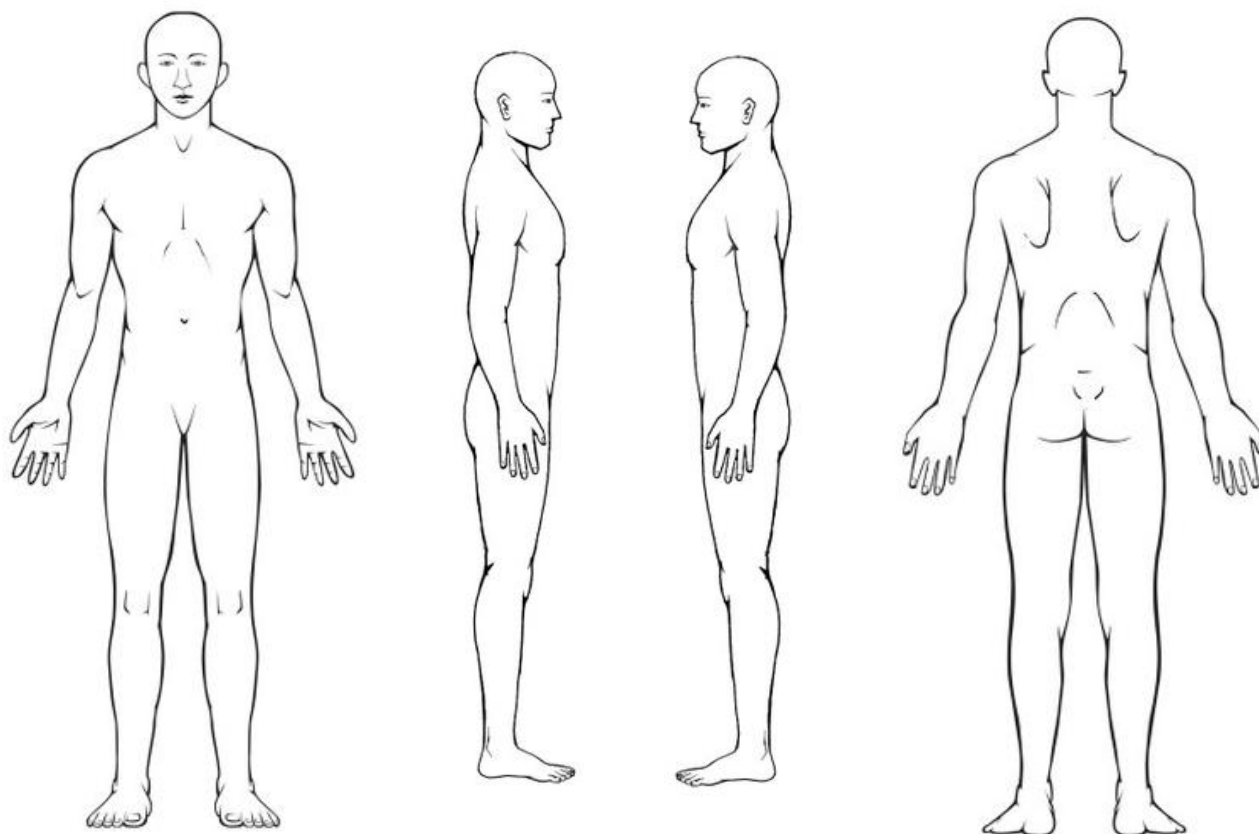
Most patients that come to our office have one of two objectives in mind concerning their healthcare. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. George will weigh your needs and desires when recommending your treatment program.

- ☐ Relief Care ☐ Corrective Care ☐ Check here if you want Dr. George to select the type of care appropriate for your condition

_____ DO NOT WRITE BELOW THIS LINE _____

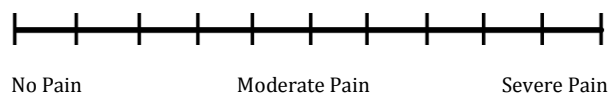
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent type(s) of pain.

D – Dull	S – Stabbing/Cutting
B – Burning	T – Tingling (Pins & Needles)
N – Numb	C – Cramping

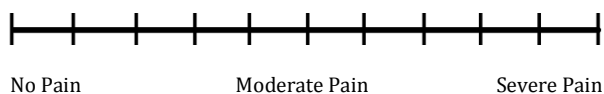


On the scales below, please draw a vertical line representing your pain or discomfort:

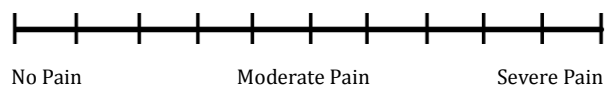
Rate the pain you have right **now**:



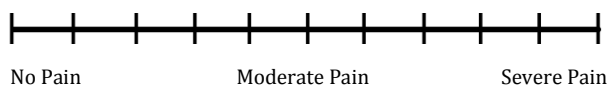
Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:



Rate your **worst** pain in the past week:



HEALTH INSURANCE SURVEY

Your Personal Injury Protection (PIP) Benefits provide \$2,000 of medical benefit reimbursement. An additional amount may be available depending on benefits available from other health insurance coverage.

If you have other benefits available to you, please complete section 1 and return this form. In addition, if you have any benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete section 2 as well.

If you do not have any other benefits available to you, please sign section 3 and return this form.

This and all other PIP information must be completed and returned to us as soon as possible.

SECTION 1

Your Name: _____

Health Insurance Company: _____

Policy Number: _____

Policy Holder (If not in your name): _____

Signature: _____ Date: _____

SECTION 2

Your Name: _____

Health Insurance Company: _____

Policy Number: _____

Policy Holder (If not in your name): _____

Signature: _____ Date: _____

SECTION 3

I certify that I do not have any accident and health benefits available to me through my own policy or that of a household member.

Signature: _____ Date: _____

AUTHORIZATION, ASSIGNMENT AND RELEASE

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking care of me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make any payment to me or you based in whole or in part upon the charges made for your services.
3. In the event of any insurance company obligated by any contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand to you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owes, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Massachusetts.
5. I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This authorization and assignment will be in continual effect until revoked by both parties.

Signature: _____ Date: _____

RECORDS RELEASE

To _____ I hereby authorize you to release to _____
Any information, including the diagnosis and records of treatment or examination, rendered to me for all care during the period from _____ to _____.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

RELEASE FROM CARE

I, _____, hereby understand that Dr. George Palaiologos is releasing me from care for my accident dated _____ and that I have reached:

☐ A pre-accident status or ☐ maximum medical improvement.

I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitation of the disclosure of your health information and your right as a patient. It is located on the last page of this packet. If you have any questions or concerns regarding the use or dissemination of your personal health information, we will be happy to address them.

I acknowledge that I have received a copy of Advanced Health Chiropractic's Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

APPOINTMENT REMINDER AND HEALTH CONCERN

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine.

You may restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if we are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of today's date. This authorization will expire seven years after the date on which you last received services from us.

Do you wish to provide us authorization to use or disclose my health information in the manner described above?

☐ Yes ☐ No

Signature: _____ Date: _____

NON-COVERED SERVICES WAIVER

I, _____, understand that the services and/or supplies rendered to me may not be eligible for benefits (e.g. service may be determined to not be medically necessary, non-covered or investigated) by _____. I understand that my health insurance has certain restrictions and limitations, such as non-covered services and/or limits to number of visits per year. Since I have chosen to receive the services, I agree to be financially responsible for any and all related charges, if not covered by my insurance.

Signature: _____ Date: _____

I, Dr. George Palaiologos D.C., certify that I have informed my patient, _____, that _____ may not cover certain services under the member's plan as they are considered non-covered services or there may be a limited number of visits per year.

Signature: _____ Date: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine and surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions. It is important to understand what to expect from chiropractic health care.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

Signature: _____

Date: _____

**EXCLUSIVE AND IRREVOCABLE ASSIGNMENT OF BENEFIT
AUTHORIZATION FOR RELEASE OF CHIROPRACTIC REPORTS
DOCTOR'S EQUITABLE LIEN
ATTORNEY'S ACCEPTANCE**

Re: Name of Patient: _____

Name of Facility: Advanced Health Chiropractic

Name of Doctor: Dr. George Palaiologos D.C.

Name of Attorney: _____

In consideration of the agreement of the doctor described above that provides me with chiropractic services, I hereby irrevocably assign to said doctor, all my right and interest in and to all insurance or indemnification benefits of any and all types. This includes, but is not limited to, automobile, Health Insurance, Personal Injury Protection (PIP) Coverage, and automobile medical payment coverage to which I may be entitled to the extent of the amount of the bill for services rendered to me on and after the above date in connection with my injury or illness, and I hereby grant to said doctor an equitable lien on any of the above-mentioned insurance benefits that may be due me, and furthermore, I authorize my doctor to provide the insurance company responsible for payment of services and my attorney with a full report concerning my condition and treatment, including, but not limited to, dates of visits and charges incurred. I further grant to said after the above date in connection with my injury or illness.

I hereby authorize and direct the immediate payment of said benefits directly to the doctor and request and direct that the above-named insurance company pay the said doctor such sums as may be due to him or her upon receipt of an itemized statement for services rendered to me by the doctor.

It is further understood and agreed that payment of said itemized statement by the above-mentioned insurance company as herein directed by me shall be considered the same as if paid directly by me. I am aware that I am personally responsible to the doctor for full amount of my bill and direct my attorney to pay the outstanding balance on my bills from the proceeds of any settlement or disposition of my case. I understand I am fully responsible for all legal fees including all attorney fees incurred in the cost of collections and I am also responsible for interest at the rate of 0.5% per month on outstanding amounts more than 60 days old.

Patient Signature: _____ Date: _____

AGREEMENT OF ATTORNEY

As an inducement for the doctor to render services to my client, I hereby do honor the above assignment and pay immediately to the doctor all sums received by me attribute to the doctor's bill and also agree to pay from the proceeds of any settlement or recovery any balance due to the doctor.

Attorney Signature: _____ Date: _____

Name of Attorney (Please Print): _____

ADVANCED HEALTH CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

USES AND DISCLOSURES

Here are some examples of how we might need to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or to your employer if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you (164.520(b)(1)(iii)(A)). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. We may also send appointment reminder postcards to your home address.
4. Your chiropractor and members of the staff may need to use your health information, examination and treatment records, and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

OUR PRIVACY PLEDGE

We have and always will respect your privacy. Other than the uses and disclosures listed above, *we will not sell or provide any of your health information to any outside marketing organization.*

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we provide health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your authorization to us at any time. However, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization (164.508(b)(5)(i)).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write us at:

Advanced Health Chiropractic
66 Main Street
Lakeville, MA 02347

YOUR RIGHT TO LIMITED USES OR DISCLOSURES

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know. In writing, notify us what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

YOUR RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION REGARDING YOUR HEALTH INFORMATION

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in another form. To help us respond to your needs, please make any requests in writing.

YOUR RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

YOUR RIGHT TO AMMEND YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our file. We require your request to be in writing and for you to give us a reason to support the change you are requesting us to make.

YOUR RIGHT TO RECEIVE AN ACCOUNTING OF THE DISCLOSURE WE HAVE MADE OF YOUR RECORDS

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1. Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. Those disclosures made to you.
3. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
4. Those disclosures for national security or intelligence purposes.
5. Those disclosures made to correctional officers or law enforcement officers.
6. Those disclosures that were made prior to the effective date of the HIPPA privacy law.

We will provide the first accounting within any 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

If you have agreed to receive privacy notices by e-main, you may request a paper copy of this notice at any time.

OUR DUTIES

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all your health information in our files.

RE-DISCLOSURE

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

YOUR RIGHT TO COMPLAIN

You may complain to us or to the secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to the address listed below.

TO CONTACT US

If you would like further information about our privacy policies and practices or a copy of this document in a larger font please contact:

Advanced Health Chiropractic
66 Main Street
Lakeville, MA 02347
508-947-0747

THIS NOTICE IS EFFECTIVE AS OF JANUARY 1, 2018. THIS NOTICE WILL EXPIRE SEVEN YEARS AFTER THE DATE UPON WHICH THE RECORD WAS CREATED.