Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

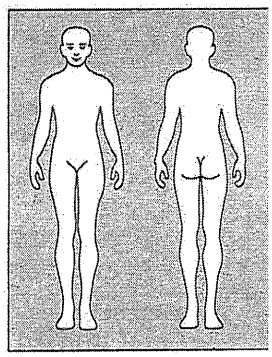
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa. We will be happy to process your insurance claims for you.

Returned checks and balances older than 90 days may be subject to collections. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for these services if the company deems they are the patient's responsibility.

We must emphasize that, as a Chiropractor, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand what I have read regarding the Financial Policy of this office and agree to payment in full of all charges deemed to be the patient's responsibility.

_____ _____

Patient's signature Date

Katz JCC
Cherry Hill, NJ

The Chiropractic Center of Cherry Hill
Dr. Scott Yorker D.C. P.C

NOTICE: THIS IS A LEGALLY BINDING AGREEMENT. Read this document carefully and in entirety. By signing this agreement, you give up your right to bring a court action to recover compensation or obtain any other remedy for any personal injury or property damage however caused arising out of your participation in Katz JCC - Cherry Hill, NJ (KJCC) Programs, and The Chiropractic Center of Cherry Hill, now or at any time in the future.

Acknowledgment of Risk

I hereby acknowledge and agree that participation in The Chiropractic Center of Cherry Hill and Katz JCC – Cherry Hill activities comes with inherent risks. I have full knowledge and understanding of the inherent risks associated with participation, including but in no way limited to: (1) slips, trips, and falls, (2) aquatic injuries, (3) athletic injuries, and (4) illness, including exposure to and infection with viruses or bacteria. I further acknowledge that the preceding list is not inclusive of all possible risks associated with The Chiropractic Center of Cherry Hill and Katz JCC - Cherry Hill participation and that said list in no way limits the operation of this Agreement.

Initial Here _____

Coronavirus / COVID-19 Warning & Disclaimer

Coronavirus, COVID-19 is an **extremely contagious** virus that spreads easily through person-to-person contact. Federal and state authorities recommend social distancing as a mean to prevent the spread of the virus. **COVID-19 can lead to severe illness, personal injury, permanent disability, and death.**

Participating in the Katz JCC programs or accessing the Katz JCC – Cherry Hill facilities including the office for The Chiropractic Center of Cherry Hill could increase the risk of contracting COVID-19. The Katz JCC – Cherry Hill in no way warrants that COVID-19 infection will not occur through participation in Katz JCC – Cherry Hill programs of accessing Katz JCC – Cherry Hill facilities.

Initial Here _____

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of my participation in The Chiropractic Center of Cherry Hill and Katz JCC programs, I, _____, the undersigned participant, agree to release and on behalf of myself, my heirs, representatives, executors, administrators, and assigns, HEREBY DO RELEASE The Chiropractic Center of Cherry Hill and Katz JCC - Cherry Hill, its officers, directors, employees, volunteers, agents, representatives and insurers ("Releasees") from any causes of action, claims, or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which I, my heirs, representatives, executors, administrators and assigns may have, now or in the future, against The Chiropractic Center of Cherry Hill and Katz JCC – Cherry Hill on account of personal injury, property damage, death or accident of any kind, arising out of or in any way related to the use of The Chiropractic Center of Cherry Hill and/or Katz JCC – Cherry Hill facilities/equipment or participation in Katz JCC – Cherry Hill programs whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to the negligence of Releasees. In consideration of my participation in The Chiropractic Center of Cherry Hill and Katz JCC – Cherry Hill programs, the undersigned participant, agree to INDEMNIFY AND HOLD HARMLESS Releasees from any and all causes of action, claims, demands, losses, or costs of any nature whatsoever arising out of or in any way related to my Katz JCC – Cherry Hill participation. I hereby certify that I have full knowledge of the nature and extent of the risks inherent in participation and that I am voluntarily assuming said risks. I understand that I will be solely responsible for any loss or damage, including personal injury, property damage, or death, I sustain while participating in all Katz JCC – Cherry Hill and The Chiropractic Center of Cherry Hill programs and that by signing this agreement I HEREBY RELEASE Releasees from all liability for such loss, damage, or death. I further certify that I am in good health without fever, cough or other symptoms related to COVID-19, that I have not been in contact within the last 14 days with anyone diagnosed or exposed to COVID-19, and that I have no conditions or impairments which would preclude my safe participation in The Chiropractic Center of Cherry Hill and Katz JCC – Cherry Hill programs. I further certify that my date of birth is _____ (MM/DD/YYYY), that my present age is _____, and that I am therefore of lawful age and otherwise legally competent to sign this agreement. I further understand that the terms of this agreement are legally binding and certify that I am signing this agreement, after having carefully read it, of my own free will. IN WITNESS WHEREOF, this instrument is duly executed this _____ day of _____, in the year _____.

_____ _____
Participants Name (Print Clearly) Phone Number

_____ _____
Participant Signature Parent or Guardian Signature

Dr. Scott E Yorker D.C.

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound / sensation in the area being treated.

Disc Herniation: Disc herniation that creates pressure on the spinal nerve or on the spinal cord is frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. this includes both in the neck and back. Yet, occasionally chiropractic treatments (adjustment, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there no available statistics to quantify their probability.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, exercises, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Dr. Scott E. Yorker D.C. DrScottYorker@gmail.com

1020 N. Kings Hwy. Suite 208
Cherry Hill, NJ 08034
Phone: 215.351.1603
Fax: 856-321-8326

Chiropractic Physician
Exercise Rehabilitation
Nutrition
Lifestyle Coaching

1301 Springdale Rd.
Cherry Hill, NJ 08003
Phone: 856-600-7389
Fax: 856-321-8326

Other problems: There may be other problems or complications that might arise from chiropractic treatment other that those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____ _____

Patient's Name Printed Today's Date

_____ _____

Patient's Signature Parent or Guardian Signature for Minor

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NOTICE OF PRIVACY PRACTICES
FOR
SCOTT E. YORKER, D.C., P.C.

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.

1. Introduction. Scott E. Yorker, D.C., P.C. is required by both federal and state law to limit the manner in which it uses or discloses information about a patient or a patient's health information. In addition, we are required to notify you of our legal obligations with respect to our privacy practices concerning your protected health information and to abide by the notice then in effect. This notice is intended to describe both the obligations of this practice with respect to information that it has about you and your rights with respect to that information.

2. What is Protected Health Information? Health information is broadly defined as any information, whether oral or recorded in any form or medium that is created or received by this practice whether the information relates to your past, present or future physical or mental health or condition, the provision of healthcare to you, or the past, present or future payment for the provision of healthcare to you. Individually identifiable healthcare information is information that includes health information and also includes demographic information collected from you that identifies you or which reasonably can be used to identify you. This is generally referred to throughout this notice as protected health information or "PHI." Scott E. Yorker, D.C., P.C. is required by law to maintain the privacy of your PHI and to provide you with this privacy notice setting forth our legal duties with respect to your PHI. This practice is required to abide by the terms of its privacy notice in effect from time to time.

3. Uses and Disclosures of Your PHI. If you are an existing patient, you have already signed a consent. If you are a new patient, you will be asked to sign a consent. The consent will authorize Scott E. Yorker, D.C., P.C. to use and disclose your PHI for your treatment, to obtain payment for the services we render to you and to assist us in our healthcare operations.

   (a) Treatment. We may use or disclose your PHI for your treatment. For example:

   $ Our medical records personnel may review your chart to ensure that all lab and other tests results have been properly placed in your chart prior to your visit.

- $ Our nurses or physicians may communicate with laboratory or other testing facilities to review test results prior to your visit.

- $ Doctors in this office may discuss your case among themselves or may review your medical treatment with referring physicians or physicians to whom they have referred you for care.

- $ Personnel in this office may discuss your medical information with a hospital or other healthcare facility where you are being admitted or being treated or we may discuss this information with another healthcare provider who is treating you at such a facility.

- $ This practice may use a sign in sheet in the waiting area which other patients may see.

- $ This practice may announce the names of patients in the waiting area, and other people in that area may hear your name.

- $ This practice may leave voice messages on your home answering machine or send postcard or other appointment reminders.

- $ This practice may send you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- $ Other types of treatment uses or disclosures may be made even if not listed above.

(b) Payment. We may use and disclose your PHI in order to obtain payment for the services we render to you. For example:

- $ This practice may submit your PHI to your insurance company in order to receive reimbursement for services rendered to you.

- $ This practice may submit your PHI to an electronic data interchange company in order to codify information for submission to a third party payor.

- $ To facilitate reimbursement, this practice may provide supplemental information to your health insurance company in order to verify the medical necessity of the care that you have obtained.

- $ We may submit information to your health insurer in order to coordinate benefits with other health insurance or public benefits that may be available to you.

- $ This practice may provide consumer reporting agencies with credit information regarding your payment history.

- $ This practice may provide information to collection agencies or our attorneys for purposes of obtaining payment of delinquent accounts.

- $ Your PHI may be disclosed in a legal action for purposes of securing payment of delinquent accounts.

- $ Other types of payment uses and disclosures may be made even if not listed above.

(c) Healthcare Operations. We may use and disclose your PHI for the healthcare operations of this practice. For example:

- $ Peer review.

- $ Quality assessment activities.

- $ Medical education and training activities.

- $ Disease management programs.

- $ Accreditation and certification activities.

- $ Business planning and development activities.

- $ Financial planning projections.

- $ Monitoring for compliance and other legal matters.

- $ General business matters.

- $ Other types of uses and disclosures may be made for healthcare operations even if not listed above.

4. Other Uses and Disclosures of PHI. In addition to payment, treatment and healthcare operations, subject to certain limitations, we may use your PHI for other purposes. The list below sets forth some examples of uses and disclosures of PHI for other purposes. Within each category are examples of such uses or disclosures, but the examples are not intended to be inclusive of all purposes for which your PHI may be used or disclosed in each particular category. There may also be overlap among the various categories.

(a) Disclosures to Federal or State Agencies. This practice will continue to make required disclosures to federal and state agencies, such as the Social Security Administration or state agencies for applications for federal or state benefits for care or payment for care.

(b) Individuals Involved in Your Care. We may disclose your PHI to someone involved in your care or payment for your care, such as a spouse, family member or close friend or a person responsible for your care, such as a nurse or home healthcare worker. We may also discuss your care with your personal representative or someone who has your healthcare power of attorney.

(c) Required by Law. This practice may use or disclose PHI when required by federal, state or local law to comply with mandatory reporting requirements, such as those involving births, deaths, child abuse, disease prevention and control, driving impairment, vaccine-related injuries, medical device-related deaths, gunshot wounds and other similar incidences that we are required to report.

(d) Workers= Compensation Insurers. We may disclose your PHI to workers= compensation insurers, state administrators, employers and other persons or entities involved in the workers= compensation system and similar proceedings.

(e) Your Legal Matters. This practice may use or disclose your PHI in response to court or administrative proceedings if you are involved in a lawsuit or a similar matter. We may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in a dispute, but only if we have received satisfactory assurances that the party seeking your PHI has made a good faith effort to inform you of the request to provide you with an opportunity to object.

(f) Public Health and Safety Matters. We may use or disclose your PHI for public health activities, including reporting communicable diseases, child abuse and neglect reports, FDA-related reports and disclosures, public health warnings to third parties regarding risk of communicable diseases or conditions, reports regarding victims of abuse, neglect or domestic violence, reports of elder abuse to the Department of Aging, reports of abuse of a nursing home patient to the Department of Public Welfare, reports to health oversight entities such as a drug enforcement agency, reports to prevent or lessen a serious threat to safety, or compliance with judicial and administrative proceedings.

(g) Law Enforcement Matters. This practice may disclose your PHI for law enforcement purposes, such as compliance with legal process, search warrants, identification of crime victims, reports of death suspected to have resulted from criminal activities, information regarding crimes, emergencies, reports regarding identification of deceased patients, cause of death, providing information to funeral directors necessary to carry out their operations, information relating to threats to public safety, or specific government functions such as military and veterans activities, national security and intelligence and similar law enforcement matters.

(h) Organ and Tissue Donation. We may use your PHI in order to facilitate organ, eye, and tissue donation and transplantation, including to those entities engaged in procuring and banking of such items.

5. Business Associates. Scott E. Yorker, D.C., P.C. may engage certain persons to perform certain of our practice functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain PHI with our billing company or computer consultant in order to facilitate our healthcare operations or payment for services provided in connection with your care. In this connection, we will require our business associates to enter into an agreement to keep your PHI confidential and to abide by the terms set forth in this privacy notice.

6. Incidental Disclosure. Certain disclosures may occur incidentally. For example, conversations regarding your medical care may be overheard by other persons or patients in the office or someone may view your name on the sign-in sheet in the waiting area. Our practice will use its best efforts to limit these disclosures, but the efficient delivery of medical care in our office setting will not permit incidental disclosures to be totally eliminated.

7. Authorizations. For all uses and disclosures that are not of the general types permitted pursuant to the terms of this privacy notice, we will obtain your written authorization to use or disclose your PHI. Any time after you have given us an authorization, you may revoke it, except to the extent that we have already relied on the authorization you have provided.

8. Your Privacy Rights. You have certain rights described below with respect to your PHI. The following will describe each of these rights and how you may exercise them:

   (a) Restrictions on Use. You have the right to request restrictions on uses or disclosures of you PHI to carry out treatment, payment and healthcare operations, but this practice is not required to agree to such requested restrictions. To request a restriction, you must submit a written request to our privacy officer. The request must state (i) what information you want restricted and (ii) to whom the restriction should apply.

   (b) Confidential Communications. You have a right to request that this practice communicate your PHI to you by reasonable alternative means or alternative locations. For example, you have the right to request that we contact you only at work or only by mail. To make such a request, you must (i) make your request in writing, (ii) the request must specify the alternative address or other method of payment, if applicable, and (iii) information as to how payment will be handled if the request would vary the way in which the practice routinely handles payment issues. We are not required to agree to requests for confidential communications that are unreasonable. We will not ask you for an explanation of why you are requesting alternative means of communication.

   (c) Right of Access. You have the right of access to inspect and obtain a copy of your PHI in the medical and billing records that we maintain about you and records that we use to make decisions about your care. This right may be subject to certain limitations, and we may impose reasonable charges for copying. To exercise your rights of access, (i) you must submit a written request to our privacy officer, (ii) the request must state how you want to retrieve the information, such as by mail, pick up, etc., (iii) the request must include the mailing address, if applicable, and (iv) the request must be accompanied by the applicable copying charge.

(d) Amendment of PHI. You have the right to request that we amend your medical and billing record that we maintain about you and records that we use to make decisions about your care. We have the right to deny your request (i) if we did not create the record (unless you provide us a reasonable basis to believe that the originator of the PHI is no longer available to act on the request), (ii) the information requested to be amended is not part of your records, (iii) the information would not otherwise be subject to a right of access, or (iv) the information is accurate and complete. Requests to amend your PHI must be made in writing and must set forth the reason why you believe the amendment is warranted or appropriate. Within sixty days of your written request for an amendment of your PHI, we will either (i) implement the amendment and notify you in writing of this and take reasonable efforts to inform others who may have received the PHI about the amendment, or (ii) notify you in writing of the reasons why we are either unable to implement the requested amendment (including a statement of your rights in connection with the denial) or inform you of our need for an additional thirty days within which to make a determination and the reasons for such an extension.

(e) Accounting of Disclosures of PHI. You have the right to receive an accounting of disclosures of your PHI made by this practice for a period of six years prior to the date of your request (but only for disclosures on or after April 14, 2003). The accounting will not include disclosures for payment, treatment and healthcare operations as described in Section 3 of this notice, disclosures to you, disclosures incident to other uses or disclosures that are permitted without your prior authorization, disclosures pursuant to your authorization, disclosures to persons involved in your care, or disclosures for national security purposes, to correctional institutions or law enforcement officials.

(f) Right to Receive a Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices. To obtain a copy, you may request one from the front desk at any office visit or you may contact our Privacy Officer.

9. Privacy Officer. Our Privacy Officer may be contacted during our regular business hours at 215-351-1603 or you may write to the Privacy Officer at:

Scott E. Yorker, D.C., P.C.
P. O. Box 63625
Philadelphia, PA 19147
Attention: Privacy Officer

10. Complaints. If you believe that your privacy rights have been violated, you may submit a complaint to our practice or to the Secretary of Health and Human Services. To file a complaint with the practice you may contact our Privacy Officer, whose contact information is set forth directly above. The practice will not retaliate against you for filing a complaint.

11. Changes to this Notice. We reserve the right to change the terms of this privacy notice and to make new provisions effective for all PHI that we maintain, including PHI that we maintain at the time of the change. If we change our policies, we will post our revised privacy notice in our waiting room and make copies available to all patients upon request. Patients may also receive a copy of our privacy policies at any time by contacting our Privacy Officer.

12. Legal Effect of this Notice. This notice is not intended to create any contractual or other rights independent of those created in the federal privacy rule.

13. Effective Date. The effective date of this notice is April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I received the Notice of Privacy Practices for Scott E. Yorker, D.C., P.C.

_____ _____

Name of Patient (Please Print) Date of Receipt

_____

Signature of Patient
(or Patient's Personal Representative, if Applicable)

_____

Please Print Name of Personal Representative
(if above signed by Personal Representative)

_____

Relationship to Patient