PROVIDER OF HOPE AND ADVANCED CARE WHEN ALL ELSE FAILS

3336 E. CHANDLER HEIGHTS RD
SUITE 123, GILBERT, AZ 85298
WWW.ASKDRKAN.COM
TEL (480)988-6269

NEW CLIENT APPLICATION

Name ____ Date ___________________

Address ____ City ____________________

State ______ Zip _____________ Date Of Birth _______________ Gender M F

Email ____________________________ Cell Phone ________________________

Facebook Name ________________________ May we contact you via FB and text Y N

Currently Pregnant? _____ Marital Status: S__ M__ D__ W__ Number of Children: ________

Occupation:______________________________ How did you hear about us?____________

Name & Number of Emergency Contact: ____

List Symptoms in Order of Priority (worst first):

1. ____
2. ____
3. ____
4. ____
5. ____

List all previous hospitalizations, surgeries, accidents, fractures, and illnesses. (Use additional pages if necessary)

1. Type: ____________________ When:_____________ Hospitalized? Y___ N___
2. Type: ____________________ When:_____________ Hospitalized? Y___ N___
3. Type: ____________________ When:_____________ Hospitalized? Y___ N___
4. Type: ____________________ When:_____________ Hospitalized? Y___ N___

Females Only:
Have you ever had an abnormal Pap Test? Yes No Reason?______________
Have you a history of ovarian cysts? Yes No Uterine fibroids? Yes No
Cervical Dysplasia? Yes No Endometriosis? Yes No

Please rate the following from 1-10, 10 being the best

energy____ sleep ____ digestion ____ bowel movement ____ mood ____ mental clarity ___

pain ____ circulation ____ mood ____ libido ____

Your Health Story

From the desk of Dr. Peter Kan:

I would like for you to share with me your "health story". This means in your own words, please tell me what you have been going through with your condition. Please be VERY SPECIFIC as this information is CRUCIAL for managing your condition correctly and to help me determine if you are a candidate for our program. If more space is needed or your hand writing is not neat, please type your response.

Pateint Name: ___________________________

When did you first noticed your symptoms? How long before you were actually diagnosed with a condition?

What type of treatments have you tried? Include medical and alternative treatments.

What type of results (or side effects) have you received from those treatments? What are your frustrations and concerns about what other doctors has done (or not done) so far?

Tell me your story, such as how your condition has gotten to this point? How is this negatively affecting you (home, relationship, work, play)? What are you not able to do/participate/enjoy as a result of your condition? Why is getting answers to your health problem important to you?

What are you most concerned about your condition? What are you afraid it might turn into? Where do you see yourself in 3-5 years if your problem is not taken care of ?

If you could paint a picture of how your body would look and feel if you didn't have your chronic condition, what would that picture look like?

What are you looking for in a doctor? What are you expecting of me?

What is the first/most important thing you would like to improve about your condition?

What do you expect from yourself if you are accepted into our natural program?

If your case is accepted, is there anything that would hold you back from beginning our natural program? If there is something, how do you foresee yourself overcoming that?

Do you have a good support system to help your through a program that will change your life?

Signature ______________________________ Date ____________

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ____________

PART I

Please list your 5 major health concerns in order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*				
How many years have you been menopausal?	______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

List the three worst foods you eat during the average week: ____________ ____________ ____________

List the three healthiest foods you eat during the average week: ____________ ____________ ____________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

PART IV

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____

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HOPE FAMILY WELLNESS & CHIROPRACTIC

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If you experience ANY pain in your body, please complete this form.

1. What is your **main complaint**? ____________________
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

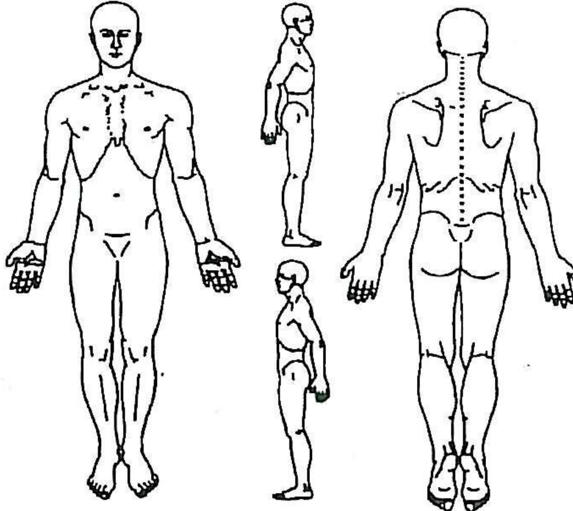
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

		Occasional			*Intermittent*			*Frequent*		*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? _______
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B**: burning pain **C**: cramping **D**: dull pain **R**: throbbing pain **N**: numbness **T**: tingling



6. When do you notice it most? ☐ AM ☐ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? ____________________
8. What makes it feel worse? ____________________
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ been hospitalized ☐ been treated by another chiropractor ☐ been treated by another specialty provider ☐ never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No
    Dates?____________ to ____________
12. Are you Pregnant? ☐ Yes ☐ No Date Due __________
13. What was the first day of your last menstrual cycle? ___________
14. Number of pregnancies? _______ Miscarriages? ____________

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

- personal care ____
- lifting ____
- reading ____
- concentrating ____
- work ____
- driving ____
- sleeping ____
- recreation ____
- walking ____
- sitting ____
- standing ____
- social life ____

Signature:______________

Date: ____/____/____

Patient Name: ______________________________ Date: _____________

Check ALL "body signals" (symptoms/pain) you may have had or do have now:

___ ADD/ADHD
___ Alcoholism
___ Allergy
___ Alzheimer's
___ Anemia
___ Appendicitis
___ Asthma
___ Arthritis
___ Backpain
___ Cancer
___ Celiac/Gluten Dis.
___ Chronic Fatigue
___ Constipation
___ Depression

___ Diabetes
___ Diarrhea
___ Eczema
___ Emphysema
___ Epilepsy/seizures
___ Fibromyalgia
___ Gall Bladder
___ Goiter
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Hepatitis

___ High Blood Pressure
___ High Cholesterol
___ High Blood Sugar
___ HIV/AIDS
___ Irregular Periods/ Cramps
___ Irritable Bowel
___ Kidney infections/ Stones
___ Low Blood Pressure
___ Low Blood Sugar
___ Lyme's Disease
___ Lupus
___ Migraine

___ Miscarriage
___ Multiple Sclerosis
___ Neck pain
___ Parkinson's Disease
___ Pneumonia
___ Raynaud's
___ Rheumatoid Arthritis
___ Ringing in Ears
___ Sinus infections
___ Stroke
___ Thyroid Problems
___ Ulcers
___ Vertigo/dizziness

Please Check all of the following conditions your family has experienced.

Mother: ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
Father: ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
GrandMother (M): ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
GrandFather (M): ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
GrandMother (P): ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
GrandFather (P): ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
Sisters: ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___
Brothers: ___ Alzheimer's ___ Cancer ___ Diabetes ___ Heart Disease ___ Parkinson's ___ MS ___ Stroke ___

List any other health conditions that you or your family have had that are not listed:

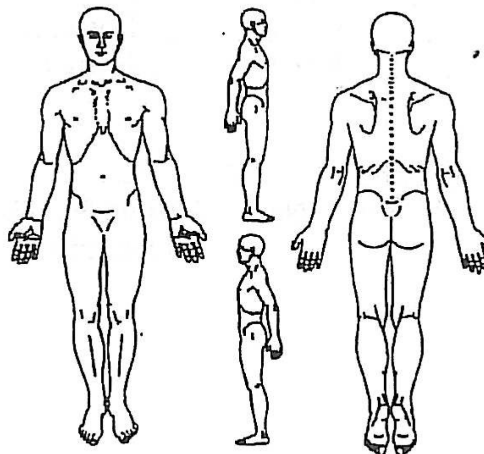
____

On a scale of 1-10, 10 being the best, rate your overall energy level, taking will power out of the equation. ____

Have you experienced any unexplained or rapid weight changes in the last six months? ___ Yes ___ No ___ lbs

Circle if you had the following dental procedures? Root canals? How many? Dental fillings? How many?

Please mark on the following diagram any scars, tattoos, body piercing you have on your body:



FCT Questionnaire – Condensed

Please watch this video link prior to your FCT appt. www.askdrkan.com/FCT

Dental History: Current number of dental amalgam fillings (these are silver or black colored): _____

How long since the first one was placed? __________ Total number that have been removed: _____

When removed? ______ Removed by (circle one): a regular dentist or a holistic mercury free dentist

Did your mother have amalgam fillings before your birth? Yes / No / Probably / No idea

And did your father and/or grandparents? Yes / No / Probably / No idea

Number of gold caps: ______ Number of root canals: __________

EMFs: Your home is a: House / Apartment / Which apartment floor?___/ How many floors? ______

How far is the nearest: cell phone tower ____ / Electricity tower ____ / Electrical substation _______

Describe the view from your bedroom window: ____

Do you use: Cordless phone / Wi-Fi / Electric blanket, shaver, toothbrush / CPAP machine

Are there fluorescent lights / striplights / long-life (mercury) lightbulbs in your: Home / Work

Do any adjacent neighbors have a cordless phone? Yes / No / No idea

How many of these are in your home? TVs ____ Computer/laptops ____ Ipad and/or other PDA__
Specifications of each TV and computer: How many are LED? ____ vs. plain LCD ____ vs. CRT __

If using a laptop, do you use a corded external keyboard & mouse? Yes / No

Average hours of use per day of the following: (include video game times) TV __ Computer or tablet __ cell phone __ landline phone ___ In a motor vehicle ___

Type of heating used in home: ______ Which room do power lines enter? _______________

Devices in your bedroom where you sleep (circle which): TV/computer/clock radio/lamp/cell phone/ other appliances: ________________________________

Toxicity: Do you smoke? Yes / No Have you ever smoked (first or second hand) Yes / No

Packs daily __________ How long ___________ When stopped ____________________

Have you used recreational drugs? Yes/No Which ____________ How long ___ When stopped ____

Have you ever been exposed to industrial/chemical toxins at work or home? Yes / No

What chemicals/what industry/how long?____

____When stopped____

Have you ever used weed killer or other agriculture chemicals? Y/N Do your neighbors? Y/N/no idea

Do you live near any of the following (i.e. within 1-2 miles, OR further is downwind) (circle which):

nuclear plant / crematorium / industrial zone / polluting factory / golf course / agricultural area

Have you ever been exposed to any other known major environmental toxins? Y / N / no idea

If yes, explain: ____

Travel: Have you ever travelled to remote regions (e.g. South America/Asia/Africa) Yes / No

Please list date, destinations, health incidents there or after?

____

Past Treatments: Approx. no. of courses of Antibiotics received in your life: 0 / 1-10 / 11-20 / 21+

For what was antibiotics prescribed for: ______________________________________

When was last one received? ______ Approx. no. of X-rays received in life: 0 / 1-10 / 11-20 / 21+

For what? mammograms / injuries / spine / dental / chest / other ________________________

Approx. no. of Vaccinations received in your life: 0 / 1-10 / 11-20 / 21+   When was last one: _______

How many pets? ___ What types? _____________________ No. of times eating out per week ____

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<u>Patient's copy, do not return</u>

NOTICE OF PRIVACY POLICY and PROTOCOL FOR SECURE STORAGE AND ACCESS OF RECORDS

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 carefully and keep this copy for your record and sign the accompanied Acknowledgement of Receipt.

Use and Disclosures
Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or 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.
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, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your service.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, email and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you, such as email newsletter, health tip, and upcoming educational workshops. 164.520(b)(I)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

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.

Right to Use Personal Information From Biographies, Letters, Notes, Pictures, Videos and Other Sources for Promotional Purposes: Any pictures, stories, videos, testimonials, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Hope Family Wellness & Chiropractic. We reserve the right to use this information about our patients (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission.

By signing the Acknowledgement of Receipt of Privacy Notice, you release to Hope Family Wellness & Chiropractic Center, its agents and employees, all rights to exhibit this work in print and electronic form publicly. You wave any rights, claims, or interests you may have to control the use of your identity or likeness in the photographs or video and agree that any uses described herein may be made without compensation or additional consideration of me.
You hereby grant Hope Family Wellness & Chiropractic Center and its agents and employees the right and license to and consents to the use, reproduction, identification, and showing in any manner of the undersigned, by live telecast, picture or film, and the quoting and publishing of any and all testimonials, comments,

statements, and endorsements made by you for the purpose of supporting or promoting chiropractic care and this office.
I am only waiving my privacy rights under HIPAA, insofar as the picture or accompanying endorsement imply or reveal that I am a patient or a former patient of Dr Peter Kan, DC. All other privacy rights under HIPAA are reserved, unless specifically released by me.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Our Privacy Pledge
We have and always will respect your privacy. Other than the uses and disclosures we described 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 disclose your health information without your consent or authorization in the following circumstances:
1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services as an inmate.
3. If we provide health care services to you in an emergency
4. If we are required by law to treat your and were unable to obtain your consent after attempting to do so.
5. 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 and noted in the uses and disclosures section above, other use of 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 received 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 consent any of your claims. If you with to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit 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 to what individuals or organizations 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 you 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 form 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 service. We may also mail and/or email 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 in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy Your Health Information
You have the right to request that we give you an account of the disclosures we have make of your health information for the last six years before the date you request. The accounting will include all disclosures except these disclosures:

6. Required for your treatment, to obtain payment for your services, or to run our practice
7. Make to you or to individuals involved in your care
8. Necessary to maintain a director of the individuals in our facility
9. For national security of intelligence purposes, as required by law
10. That were made prior to the effective date of the HIPPA privacy law

We will provide the first accounting within 12 months 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 of modify your request.

PROTOCOL FOR THE SECURE STORAGE, TRANSPORT AND ACCESS OF YOUR MEDICAL RECORDS
If the doctor terminates or sells the practice and the your medical record will not remain in the same physical location, the doctor will notify you in writing to your last known physical address at least 30 days before the doctor terminates or sells the practice to inform you regarding the future location of your medical records. The doctor will also include information at that time on how you may access your medical records once the doctor terminates or sells his practice.

State law requires the doctor to maintain your medical records for at least 5 years after your last treatment date. For minors under age of 18, their medical records must be kept for at least 5 years after their 18th birthday. Any unclaimed medical records after that period will be shredded and disposed of to protect your identity and privacy. This will only be done after the doctor has made a good faith attempt to reach you in writing to your last known physical address 30 days prior to document disposal.

The doctor will respond only to written request for copies of your medical record. This will be done within 14 days of the written request with your authorized signature.

In compliance to recently passed House Bill 2786, which added Arizona Revised Statute 32-3210.

Your Right to Obtain a Paper Copy of This Notice
If you have agreed to the privacy notice by email, 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 notice. If we make a change to the terms of 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 whim we provide the information and may not longer be protected by 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 any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Dr. Peter Kan, Clinical Director, at our office address shown at the top of the opposite page.

To Contact Us
If you would like further information about our privacy policies and practices, please contact Hope Family Wellness & Chiropractic Center at our office address or by phone at (480)988-6269. This notice is effective as of May 14, 2010 or the date of your signed acknowledgement of receipts of this notice. This notice will expire six years after the date upon which the record was created.

PROVIDER OF HOPE
AND ADVANCED CARE
WHEN ALL ELSE FAILS

3336 E. CHANDLER HEIGHTS RD
SUITE 123, GILBERT, AZ 85298
WWW.ASKDRKAN.COM
TEL (480)988-6269

Acknowledgement of Receipt of Notice of Privacy Policy and Protocol for the Secure Storage, Transport and Access of Your Medical Records

I acknowledge that I have read and received a copy of this notice. By my signature, I hereby agree to the release and use of protected health information and testimonials to Hope Family Wellness & Chiropractic as outlined in the Privacy Notice. I choose to opt-in to receive emails from Hope Family Wellness & Chiropractic to my email on file for purposes of office communication and educational purposes such as health tips and patient newsletter.

____

Print Patient Name

____ ____________________

Patient Signature Date

____

Guardian of Minor - Print Name

____ ____________________

Guardian of Minor - Signature Date

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Consent to Treat and Acknowledgement of Conditions for Acceptance of Care

Please read before signing:

- I completely understand there are no guarantees of help, correction, relief, or cure, written, spoken or implied. I also agree and understand that Dr Kan and Hope Family Wellness & Chiropractic Center may be managing my case based on his chiropractic license alone and do NOT treat cancer, disease, or any medical diagnosis.
- I understand that this care does NOT promote or practice medicine, and therefore does NOT bill insurance for non-recognized services. In this understanding, I fully understand that I cannot expect any insurance payment for services rendered and will not seek reimbursement for any care received. (NO superbill will be issued)
- We make no attempts to cure any "condition." We make no claims or imply any claims that suggestions are given to cure any condition. We do not claim that any nutritional supplements such as vitamins, minerals, herbs, or proteins will cure any condition, nor that its purpose is to cure any condition.
- We do not diagnose or treat disease. Nothing we do or imply should be construed as such. We attempt to ascertain factors about your nutritional health. We do not attempt to interfere with medical advice in any way. We cannot advise you on your medication given to you by your M.D. or any other doctor. Please always ask your M.D. for advice on your medication.
- Dr. Peter Kan, D.C. is not a medical doctor, nor does he portray himself as such. Dr. Kan does not treat or care for medical emergencies. I understand that if I am in great pain or discomfort, I should seek MEDICAL TREATMENT.
- Our approach to helping you is to identify deficiencies, toxicities and imbalances in your physiology that may interfere with optimal function, and to recommend lifestyle changes and solutions to restore balance, and thus allowing the body to heal itself. Our methods complement your current medical treatment.
- I understand that should I discontinue care for any reason, all fees accrued for care received are based on current clinic fee schedules and are based per visit and per service received. I agree to pay for all services received at the time of service. If I pre-paid for any care, a refund may be due after the services received have been deducted from the amount paid. Any balance on my account is due and payable immediately.
- I understand that if I do not follow his recommendations, it is unlikely that I will receive significant benefit from his program. As such, I accept Dr. Kans' recommendations and agree to commit to the plan he has presented to me.
- I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature below:

Print Name: ____

Signature: ____

Date: ___________________________

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Authorization to Share Medical Information

I, _________________________, authorize Hope Family Wellness & Chiropractic Center to share and/or receive confidential information with:

Name of Agency/Person____

Address____

City__________________________________ State___________ Zip _____________

Phone________________________________ Fax_______________________________

The exchange of this information is for official purposes only and may be shared electronically, verbally or written by or with a duly designated representative of Hope Family Wellness & Chiropractic Center. I understand that information may be shared via fax, US postal service, photo static copy, electronically or in person.

Please release the following information:

- Problem List ____
- Medication List____
- Lab Results____
- Chart Notes____
- Imaging Report____
- X-ray films____
- Other____
- Complete Medical File____

I understand that I am not required to sign this authorization and that I may revoke this authorization at any time in writing to Hope Family Wellness & Chiropractic Center. The revocations will be effective as of the date of receipt by Hope Family Wellness & Chiropractic Center, except to the extent that action based on this authorization has already taken place.

Print Name____ Date of Birth ____/____/____

Signature____ Date ________________

Witness____ Date ________________