Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State: _____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Office Use Only
□ 1
□ 4-5
□ >5

Patient #:_____

Pain Drawing

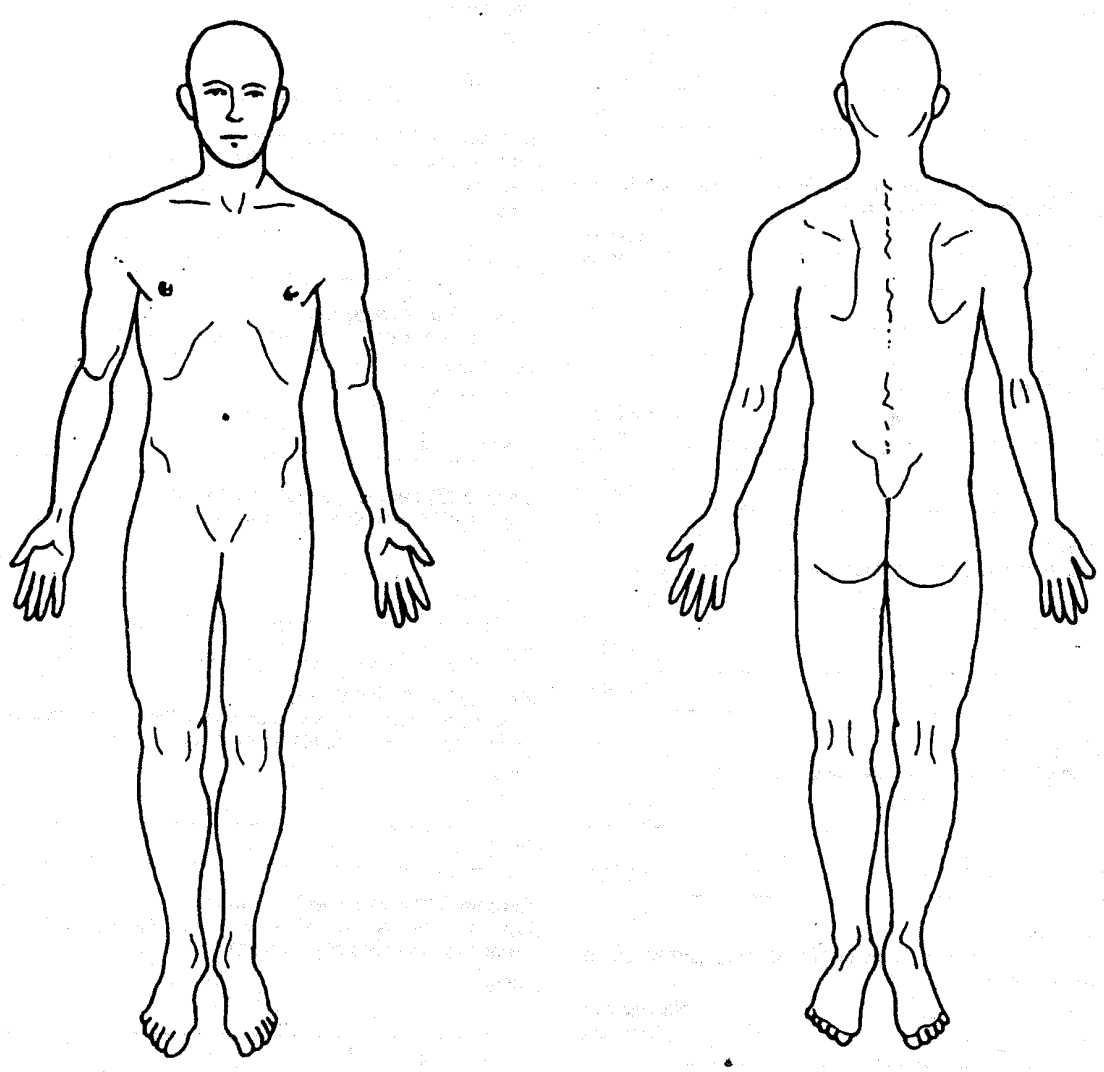
Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / Throbbing ~ ~ ~ ~ ~ ~



Choose this form for low back and leg-related symptoms and choose the neck form for neck, mid-back and arm-related symptoms

Oswestry Disability Index

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally but it is very painful.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

- **Neck Disability Index**

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)

- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Notice of Patients Rights and Privacy Protections under Federal Privacy Laws (HIPAA)

The Health Insurance Portability and Accountability Act of 2013, commonly referred to as HIPAA, requires this office to implement and maintain a number of policies and safeguards to insure that patients' protected health information (PHI) remains secure and only used in a manner consistent with HIPAA and similar laws.

General Rules and Definitions.

Protected Health Information, also referred to as PHI means any patiently identifiable health information, including demographic data, which relates to:

- the patient's past, present or future physical or mental health or condition,
- the provision of health care to the patient, or
- the past, present, or future payment for the provision of health care to the patient,

and identifies the patient or for which there is a reasonable basis to believe it can be used to identify the patient. Patiently identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Covered Entity means: a) any health care provider, including this office, b) Health Plans, such as a health insurance company, an HMO, government health programs such as Medicare and Medicaid, c) a health care clearing house that processes nonstandard health information from one covered entity into a standard format, such as a billing agent.

Minimum Necessary. A central aspect of HIPAA is the principle of "minimum necessary" use and disclosure. This office will make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. This office will develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, this office will not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a health care provider for treatment; (b) disclosure to an patient who is the subject of the information, or the patient's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

For the purposes of the minimum necessary requirement, the following employees/positions have the corresponding access to PHI:

Doctor or other health care provider who treats or directs treatment of patients: All PHI related to the patient under the doctor's care, or as the office's electronic billing/records system permits, necessary to diagnose, treat and perform other healthcare operations

Chiropractic Assistant or Chiropractic Technical Assistant (as certified by the state or Integrity Management): All PHI related to the patient under the doctor's care, or as the office's billing/electronic records system permits necessary to treat and perform other healthcare operations.

Billing: All PHI as is minimally necessary to perform the duties of billing or obtain prior authorization of services, including, but not limited to, demographic information and doctor's notes, patients' medical history or as the office's electronic billing/records system permits.

Front Desk/Receptionist: All PHI as is minimally necessary to schedule appointments for patients and process patient's demographic and billing information or as the office's electronic billing/records system permits. This may include patients' demographic information, health care payer information, and statements made by the patient regarding their current or past medical condition.

Practice Representative: All PHI as is minimally necessary to schedule appointments for patients or as the office's electronic billing/records system permits.

We recognize that our office may have employees covering several positions on a temporary or permanent basis. Therefore the level of access to PHI shall be as necessary to perform the functions of the position.

Business Associate: In general, a Business Associate is defined by HIPAA as a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of patiently identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing. Business Associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. *However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all.* A covered entity can be the business associate of another covered entity.

Personal Representatives. HIPAA requires a this office to treat a *"personal representative"* the same as the patient, with respect to uses and disclosures of the patient's protected health information, as well as the patient's rights under the Rule.[84] A personal representative is defined by HIPAA as a person legally authorized to make health care decisions on an patient's behalf or to act for a deceased patient or the estate. HIPAA permits an exception when we has a reasonable belief that the personal representative may be abusing or neglecting the patient, or that treating the person as the personal representative could otherwise endanger the patient.

Special Case: Minors. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise patient rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, HIPAA defers to State and other law to determine the rights of parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor's protected health information, our office has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional, such as our doctor, in the exercise of professional judgment.

General Principles for Uses and Disclosures of PHI

Basic Principle. A major purpose of HIPAA is to define and limit the circumstances in which an patient's protected heath information may be used or disclosed by covered entities. This office may not use or disclose protected health information, except either: (1) as the HIPAA laws permits or requires; or (2) as the patient who is the subject of the information (or the patient's personal representative) authorizes in writing.

Any information that is disclosed should be the minimum amount of information necessary to accomplish the task, such as submitting a bill to an insurance company or obtaining a prior authorization.

Required Disclosures. This office must disclose protected health information in only two situations: (a) to patients (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to US Department of Health and Human Services when it is undertaking a compliance investigation or review or enforcement action.

Permitted Uses and Disclosures of PHI

Permitted Uses and Disclosures. This office is permitted to use and disclose protected health information, without an patient's authorization, for the following purposes or situations: (1) To the Patient (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. We will rely on our professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

(1) To the Patient. This office may disclose protected health information to the patient who is the subject of the information.

(2) Treatment, Payment, Health Care Operations. This office may use and disclose protected health information for its own treatment, payment, and health care operations activities. We may also disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the patient and the protected health information pertains to the relationship.

a) ***Treatment*** is the provision, coordination, or management of health care and related services for a patient by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

b) ***Payment*** encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an patient and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an patient.

c) Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

In the unlikely event this office might, obtain, use or disclosure psychotherapy notes for treatment, payment, and health care operations purposes, we will require a written authorization from the patient prior to use or disclosure of the psychotherapy notes..

(3) Uses and Disclosures with Opportunity to Agree or Object. Informal permission may be obtained by asking the patient outright, or by circumstances that clearly give the patient the opportunity to agree, acquiesce, or object. Where the patient is incapacitated, in an emergency situation, or not available, this office may generally make such uses and disclosures, if in the exercise of our professional judgment, the use or disclosure is determined to be in the best interests of the patient.

Facility Directories. It is a common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on a patient's informal permission to list in its facility directory the patient's name, general condition, religious affiliation, and location in the provider's facility. The provider may then disclose the patient's condition and location in the facility to anyone asking for the patient by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the patient by name when inquiring about patient religious affiliation. We do not anticipate creating such a Facility Directory, but we need to advise you of the scope of the rule.

For Notification and Other Purposes. This office may also rely on a patient's informal permission to disclose to the patient's family, relatives, or friends, or to other persons whom the patient identifies, protected health information directly relevant to that person's involvement in the patient's care or payment for care. This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient. Similarly, a covered entity may rely on an patient's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the patient's care of the patient's location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

(4) Incidental Use and Disclosure. The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as this office has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the "minimum necessary," as required by HIPAA.

(5) Public Interest and Benefit Activities. HIPAA permits use and disclosure of protected health information, without a patient's authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the patient privacy interest and the public interest need for this information. Those purposes are:

Required by Law. This office may use and disclose protected health information without patient authorization as required by law (including by statute, regulation, or court orders).

Public Health Activities. This office may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) patients who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer

to comply with the Occupational Safety and Health Administration (OHSA), the Mine Safety and Health Administration (MHSA), or similar state law..

Victims of Abuse, Neglect or Domestic Violence. In certain circumstances, this office may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.[31]

Health Oversight Activities. This office may disclose protected health information to health oversight agencies, as defined by HIPAA, for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Judicial and Administrative Proceedings. This office may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the patient or a protective order are provided.

Law Enforcement Purposes. This office may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Decedents. This office may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.

Cadaveric Organ, Eye, or Tissue Donation**.** This office may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

Research. "Research" is defined by HIPAA as any systematic investigation designed to develop or contribute to generalizable knowledge. HIPAA permits this office to use and disclose protected health information for research purposes, without an patient's authorization, provided the covered entity obtains either: (1) documentation that an alteration or waiver of patients' authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the patients about whom information is sought. A covered entity also may use or disclose, without an patients' authorization, a limited data set of protected health information for research purposes

Serious Threat to Health or Safety. This office may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). This office may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

Essential Government Functions. An authorization is not required to use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Workers' Compensation. This office may disclose protected health information as authorized by, and to comply with, workers' compensation laws and other similar programs providing benefits for work-related injuries or illnesses.

6) Limited Data Set. A limited data set is defined by HIPAAA as protected health information from which certain specified direct identifiers of patients and their relatives, household members, and employers have been removed. A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

Privacy Practices Notice. Our office, with certain exceptions, must provide a notice of its privacy practices. HIPAA that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state our office's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe patients' rights, including the right to complain to HHS and to this office if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to our office. We must act in accordance with their notices. HIPAA also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans.

Notice Distribution. For every patient of our office, we must have delivered a privacy practices notice to patients starting April 14, 2003 as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);
- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and
- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

We must also supply notice to anyone on request. Our office will also make its notice electronically available on any web site it maintains for customer service or benefits information.

- **Acknowledgement of Notice Receipt.** Our office must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice. HIPAA does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Patient's Rights

Access. Except in certain circumstances, patients have the right to review and obtain a copy of their protected health information within 30 days of the request. HIPAA excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, our office may deny a patient access in certain specified situations, such as when a health care professional believes access could cause harm to the patient or another. In such situations, the patient must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.

Electronic Access If your PHI is maintained in an electronic format, you have a right to an electronic copy of that information within 30 days of your request. If our system cannot readily provide it to you in your requested format, we will seek to agree upon a mutually acceptable format. As a last resort, we may have to provide you a paper copy.

Amendment. HIPAA gives patients the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. If we accept an amendment request, it must make reasonable efforts to provide the amendment to persons that the patient has identified as needing it, and to persons that the covered entity knows might rely on the information to the patient's detriment. If the request is denied, covered entities must provide the patient with a written denial and allow the patient to submit a statement of disagreement for inclusion in the record. HIPAA specifies processes for requesting and responding to a request for amendment. We must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Disclosure Accounting. Patients have a right to an accounting of the disclosures of their protected health information by this office or our business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before its HIPAA compliance date.

HIPAA does not require accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to the patient or the patient's personal representative; (c) for notification of or to persons involved in an patient's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or patients in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Restriction Request. Patients have the right to request that this office restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the patient's health care or payment for health care, or disclosure to notify family members or others about the patient's general condition, location, or death. Such requests should be documented in writing and maintained in the patient's record.

Restriction Request for Services Paid "Out-of-Pocket." Patients have the right to request that this office not disclose to a patient's health insurance company, HMO or other payer any PHI related to any treatment the patient has elected to pay "out-of-pocket." The patient must complete the "HIPAA REQUEST FOR NON-DISCOSURE OF PHI RELATING TO SERVICES PAID DIRECTLY BY PATIENT" form to document the request and should be maintained in the patient's record.

Confidential Communications Requirements. Our office must permit patients to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs. For example, an patient may request that we communicate with the patient through a designated address or phone number. Similarly, a patient may request that the provider send communications in a closed envelope rather than a post card. Such requests should be documented in writing and maintained in the patient's record.

Right to Revoke Authorization or Consent to Use PHI for Marketing or Fundraising Purposes. Patients have the right to revoke their consent or authorization to disclose or use their PHI for any fundraising or marketing purposes. The patient must complete the "HIPAA REVOCATION OF AUTHORIZATIONS OR CONSENT TO USE PHI FOR MARKETING OR FUNDRAISING PURPOSES" form to document the request and should be maintained in the patient's record. A list of all patients electing to opt out

The patient should be advised that they may still receive marketing and fundraising communications, but their name and other demographic information will have been derived from sources other than PHI, such as the White Pages or a community marketing list.

Sale of PHI. This office will not sell your PHI. However, we are legally required to inform you that if we were to sell your PHI, we must first y obtain your authorization.

Right to Revoke All Authorizations or Consent to Use or Disclose PHI. Patients have the right to revoke any or all authorizations to use or disclose PHI by this office. The patient must complete the "HIPAA REVOCATION OF ALL AUTHORIZATIONS OR CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION" form to document the request and should be maintained in the patient's record. The patient should be advised that this revocation may affect this office's ability to maintain the patient as a patient and treat them in the future.

Right to be Notified of a Breach. Patients have the right to be notified of a breach of the security of your PHI, unless there is a low probability your PHI has been compromised.

Administrative Requirements

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore the flexibility and scalability of the Rule are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their own environment. What is appropriate for a particular covered entity will depend on the nature of the covered entity's business, as well as the covered entity's size and resources.

Privacy Policies and Procedures. A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.[64]

Privacy Personnel. Our office has designated Jeremy Cayer, DC as our Privacy Official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing patients with information on this office's privacy practices.

Mitigation. We must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.

Data Safeguards. This office must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of HIPAA and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. Our office shall practice to ensure reasonable safeguards for patients' health information – for instance:

- By speaking quietly when discussing a patient's condition with family members in a waiting room or other public area;
- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information

Documentation and Record Retention. Our office will maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that HIPAA requires to be documented.

Changes to this Notice. We reserve the right to change this notice. Any changes contained in the new notice will apply to Health Information already in the possession of our office as well as any information we receive in the future. A current copy of the notice will be posted in the office and on our website, if we have a website.

Complaints

Complaints. Any complaints regard our privacy policies or procedures should be directed to our Privacy Officer, who is Jeremy Cayer, DC

Retaliation and Waiver. This office will not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. Our office will not require a patient to waive any rights not under HIPAA as a condition for obtaining treatment.

HEALING TOUCH
CHIROPRACTIC
IT'S TIME TO FEEL HEALTHY

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On subsequent visits, payment may be made at the beginning of the week for all of your scheduled visits that week. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 120 days after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We will be preferred providers following a 90 day processing period for the following companies: Cigna, Aetna, United, Kaiser, and Blue Cross/ Care First.

☐ You are required to pay your co-pay at the time of service.

☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

☐ Benefits are available for up to _____visits per year. A $_____co-pay is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Healing Touch Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Healing Touch Chiropractic and my insurance company. I request that Healing Touch Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Healing Touch Chiropractic that fees will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name:_____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $_____co-pay of each visit due by you.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)