Phillips Chiropractic

Where wellness begins

Chiropractic ~ Acupuncture ~ Nutrition

4010 NW Cache Road ~ Lawton, OK 73505

Phone: 580-357-8688 ~ Fax: 580-357-7483

AUTHORIZATION TO ENDORSE CHECKS

I, ________________________, have or will have incurred certain financial obligations for chiropractic services rendered by Phillips Chiropractic and/or Dr. Phillips.
I understand that I may be entitled to receive compensation for said obligations or expenses from any insurance carriers.
I specifically authorize Phillips Chiropractic and/or Dr. Phillips to receive any insurance company checks as payment for the chiropractic services, and to endorse, deposit, and negotiate said checks in payment of my financial obligation to Phillips Chiropractic and/or Dr. Fred B. Phillips.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment. I understand that the physician/clinic has the right to expect good faith payments on my account and that a full payment is being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full. This authorization shall remain valid unless and until revoked in writing by me.

Signed: ________________________ **Date:** __________ **Acct#** ____________
Print Patient's Name: ________________________ **Witness:** ____________________
Date of Accident: ___/____/______ **Location of Accident:** ________________________

3RD PARTY:

Company: ______________________

Attn:/Adj: ______________________

Address: ______________________

____

Phone: ______________________

Pol/Clm: ______________________

Insured: ______________________

ATTORNEY:

Name: ______________________

Attn: ______________________

Address: ______________________

____

Phone: ______________________

MEDICAL PAY/PIP/and/or UM:

Company: ______________________

Attn:/Adj: ______________________

Address: ______________________

____

Phone: ______________________

Pol/Clm: ______________________

Insured: ______________________

MAJOR MEDICAL:

Company: ______________________

Address: ______________________

____

Phone: ______________________

Pol/Clm: ______________________

Insured: ______________________

A Fax From:

Phillips Chiropractic
Where wellness begins
4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

FAX NUMBER: ___________________________ PAGES: (including cover page): ______

DATE: ______________ATTENTION: ________________________FROM: ____________________________

Request for Medical Records

By signature below I authorize:

____________________________________to release identifiable information from the medical record(s) of: (Patient's Name) _____________________________________ to Phillips Chiropractic, 4010 NW Cache Road, Lawton, OK 73505.

Or, By signature below I authorize:

Phillips Chiropractic to release identifiable information from the medical record(s) of: (Patient's Name) _______________________________________ to ____.

Describe protected health information, date, type, or origin:
____

This protected health information is being used or disclosed for the following purposes: The evaluation and diagnosis of my health.

This authorization shall be in force and effect until ______________________________.

The information authorized for release may include information which may be considered a communicable or venereal disease, which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus know as acquired immune deficiency syndrome (AIDS).

____ Signature of Patient or Personal Representative	_______________________ Date
____ Print Name of Patient or Personal Representative	_______________________ Social Security Number
____ Description of personal Representative's Authority	_______________________ Patient's Date of Birth

CC: Patient

The information contained in the transmission accompanying this notice is confidential and protected by the physician and patient privilege. It is intended only for the use of the individual or entity identified below. If the render of this message is not the intended recipient, you are hereby notified that any dissemination or distribution of the accompanying communication is prohibited. The parties sending the accompanying documents do not waive the physician and patient privilege. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address below via the United States Postal Service.

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Date: ________________Patient# ______________

Chiropractic Patient Information

Name: _______________________________ Address (mailing): ______________________________City: _________________

State: ______ Zip:___________+(4)_______ Home Phone: _________________________Cell _____________________________

E-mail address:____

Race (circle only 1) : American Indian Alaskan Native Asian White Black or African American Native Hawaiian Other Pacific Islander Declined to State

Ethnicity (circle only 1) Hispanic or Latino Not Hispanic or Latino Declined to State **Preferred Language:** ____________

Marital: M S W D Age: _____ Birth Date: _________________ Social Security #________________________

How were you referred to our office? ____

Occupation: __________________ Employer: ________________________Employer's Address: ________________________

Work Phone: _____________________________

Spouse:__________________ Occupation:______________ Employer:____

How many children? ____________ Names and Ages of Children: ____

Name of Nearest Relative: ______________________ Address: ____________________________ Phone:__________________

Family Medical Doctor: ____When doctor's work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ____

HISTORY OF PRESENT ILLNESS: List in order of severity if more than one:

Chief Complaint: (Purpose of this appointment): ____

Date symptoms appeared or accident happened: ____

Is this due to: □Auto □Work □Other: ____ Days lost from work: __________

Have you ever had the same or a similar condition? □ Yes □ No If yes, when: ____

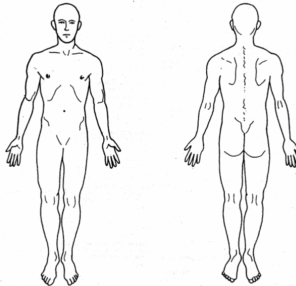
Treatment already received: □ Medication □ Physical Therapy □ Surgery □ Chiropractic □ None □ Other

Name and address of Doctor(s) who have treated you: ____

Date of last: Physical examination: _________ Spinal Exam: ________ Spinal X Rays: ________ Chest X Rays: ________
MRI________ CT_______ Bone Density ______Bone Scan _________ Blood Test: _______ Urine Test: _____________

Please Indicate Region of Complaint

- □ HEADACHE PAIN
- □ NECK PAIN
- □ LOW BACK PAIN
- □ SHOULDER PAIN
- □ ELBOW PAIN
- □ WRIST PAIN
- □ HAND PAIN
- □ HIP PAIN
- □ KNEE PAIN
- □ ANKLE PAIN
- □ FOOT PAIN
- □ TMJ
- □ UPPER/MID BACK PAIN
- □ OTHER ____________________



Use the letters listed below to indicate the *type* and *location* of your pain and sensations...

KEY

A = ACHE B = B BURNING
S = STABBING N = NUMBNESS
P = PINS & NEEDLES
O = OTHER

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check all conditions that apply to you)

□ Broken or Fractured Bones	□ Osteoarthritis	□ Eating Disorder	□ Heart Disease	□ Prosthesis
□ Circulatory Problems	□ Osteoporosis	□ Alcoholism	□ COPD	□ Psychiatric Care
□ Rheumatoid Arthritis	□ Pace Maker	□ Drug Addiction	□ Migraines	□ Thyroid
□ Seizures/Convulsions	□ Diabetes	□ HIV Positive	□ Vaginal Infections	□ STD
□ A Congenital Disease	□ Cancer	□ Gall Bladder	□ Ulcer	□ Kidney disease
□ Excessive Bleeding	□ Ruptures	□ Depression	□ Prostate	□ Reflux
□ High □ Low Blood Pressure	□ Coughing Blood	□ Epilepsy	□ Liver Disease	□ Other________

Do you have a history of stroke or hypertension?____

Smoking Status: Start Date: _________End Date:__________ Currently (circle): Every Day / Some Days / Quit / Never

In an effort to quit smoking, I am currently taking; __________________

Patient's Initials ________________

Date:__________________Patient Name:______________________________________Patient #______________________

Are you currently taking any medications, including over the counter? Yes No If Yes, please indicate the following:

Medication: _____________mg_____
Route: (circle 1) Oral Tab/Capsule
Intravenous
Other: ___________
Frequency: _____________________
Began Use: ____________________
Discontinued Use: _______________

Medication: ____________mg____
Route: (circle 1) Oral Tab / Capsule
Intravenous
Other: _________
Frequency: ___________________
Began Use: ___________________
Discontinued Use: _______________

Medication: ____________mg____
Route: (circle 1) Oral Tab / Capsule
Intravenous
Other ________
Frequency: _________________
Began Use: _________________
Discontinued Use:_____________

If there are more than three medications we can call your pharmacy for your list or bring all bottles on next visit.

Do you have any allergies to medication? Yes No If Yes, please indicate the following:

MEDICATION ALLERGIES	SEASONAL ALLERGIES	VITAMINS/HERBS/MINERALS
________________________________	________________________________	________________________________
________________________________	________________________________	________________________________
________________________________	________________________________	________________________________

EXERCISE	WORK/HOME ACTIVITY	HABITS	HOBBIES
□ None	□ Sitting	□ Alcohol: Drinks/Day _____	________________________
□ Moderate	□ Standing	□ Caffeine: Drinks/Day _____	________________________
□ Daily	□ Light Labor	□ High Stress Level: Reason?	________________________
□ Heavy	□ Heavy Labor		

SURGERIES/INJURIES	Description:	Date
Falls	____	_________________________
Head Injuries	____	_________________________
Broken Bones	____	_________________________
Dislocations	____	_________________________
Surgeries	____	_________________________

Please list any other health problems you have, no matter how insignificant they may be:
____

What percentage of time during the day (at home / your job / away from home) do you spend:
Lifting: ________ Pulling ________ Pushing ______ Sitting: ________ Bending: _________ Working at a computer: ___________

FAMILY HISTORY: Parents: (check one)
Father: □ living □ deceased □ Current age if still living: _______ Cause of death and age at death if deceased: _______
Mother: □ living □ deceased □ Current age if still living: _______ Cause of death and age at death if deceased: _______
Do you have any family members who suffer from the same condition you do? □ Yes □ No If so, please list:

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

_______ Tuberculosis _______ Cancer _______ Mental Illness _______ Kidney Disease
_______ Diabetes _______ Asthma _______ Heart Disease _______ Liver Disease
_______ Stroke _______ Arthritis _______ Lung Disease _______ Other

Please check any and all insurance coverage applicable in this case**:** □ Major Medical □ Medicare □ Medigap/supplemental
□ Medicare secondary insurance □ Auto Accident □ Worker's Comp □ Medical Savings Acct & Flex Plans □ Other

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

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Phillips Chiropractic. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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. I authorize Phillips Chiropractic to communicate with my primary care physician and to use my name on a referral board when I refer.

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. If there is anyone you do not want to receive your medical records, please inform our office.

☐ **Check this box of you would like to have access to your Electronic Health Records**

Patient's Signature ____ Date ________________________

Guardian's Signature Authorizing Care ____ Date ________________________

Date: _____________ Patient Name: ____________________________________ Patient # ___________

SUMMARY

1. What is your major symptom?____

2. What does this prevent you from doing or enjoying?____

3. If this is a recurrence, when was the first time you noticed this problem?________________________________
How did it originally occur?____

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually Worse
If yes, when and how? ____

4. How frequent is the condition? □ Daily □ Constant □ Intermittent □ Night Only
How long does it last? □ All Day □ Few Hours □ Minutes

5. Are there any other conditions or symptoms that may be related to your major symptom?
□ Yes □ No If yes, describe: ____
Are there other unrelated health problems?
□ Yes □ No If yes, describe: ____

6. Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □ Aching
□ Burning □ Stabbing □ Other: ____

7. Is there anything you can do to relieve the problem? □ Yes □ No If yes, describe _________________________
_____________________. If no, what have you tried to do that has not helped? ______________________________
____

8. What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending
□ Lifting □ Twisting □ Other: ____

9. List any major accidents you have had other than those that might be mentioned above: ___________________
____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
□ Yes □ No □ Uncertain

1	2	3	4	5	6	7	8	9	10
No Pain or Dis-comfort.	Slight Dis-comfort	Pain that does not affect my activity	Pain that affects my daily activities	Pain that prevents performing my daily activities	Pain that limits my work schedule	Pain that prevents working at all	Pain that prevents work and all personal activity	Pain that keeps me bed ridden	Pain that makes you cry out.

Patients Signature ____ Date _______________

Guardian's Signature Authorizing Care ____________________________ Date _______________

OFFICE NOTES:
____
____
____
____
____

Doctor's Signature ____ Date _______________

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Date: _______________ Patient Name: _________________________ Patient #: _______

Review of Systems

Have you had any of the following symptoms lately? Please Circle

Symptom		
General		
Fatigue	Yes	No
Fever	Yes	No
Weight Loss	Yes	No
Chills	Yes	No
Eyes		
Blurred vision	Yes	No
Vision Changes	Yes	No
Ears		
Ear Pain	Yes	No
Hearing Loss	Yes	No
Nose, Throat		
Nasal congestion	Yes	No
Bloody nose	Yes	No
Lungs		
Shortness of Breath	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Heart		
Chest Pain	Yes	No
Shortness of Breath while sleeping	Yes	No
Breasts		
Drainage from nipple	Yes	No
Breast lump	Yes	No
Gastrointestinal		
Nausea	Yes	No
Vomiting	Yes	No
Changes in bowels	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No
Urinary		
Frequent urination	Yes	No
Painful urination	Yes	No
Blood in urine	Yes	No
Urinary leakage	Yes	No
Gynecological (Women Only)		
Vaginal discharge	Yes	No
Abnormal vaginal bleeding	Yes	No
Menstrual problems	Yes	No
Pelvic pain	Yes	No
Hematologic		
Bruises easily	Yes	No
Prolonged bleeding	Yes	No
Musculoskeletal		
Joint pain	Yes	No
Muscle pain	Yes	No
Back Pain	Yes	No
Skin		
Skin rash	Yes	No
Itching	Yes	No
Neurological		
Headaches	Yes	No
Dizziness	Yes	No
Numbness	Yes	No
Psychiatric		
Difficulty sleeping	Yes	No
Feeling anxious	Yes	No
Feeling depression	Yes	No
Endocrine		
Intolerant of cold	Yes	No
Intolerant of heat	Yes	No

ACCIDENTAL INJURY FORM

NAME_______________________________________ TODAYS DATE________________________

Date of Accident__________ Time: _____am ______pm Location of Accident_________________

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

Did you strike any of the following? (Check all that apply) ( ) Steering Wheel ( ) Air Bag

( ) Dashboard ( ) Rear-view mirror ( ) Windshield ( ) Car interior ( ) other: ______________________________

Did you receive any of the following: ___Cuts ___ Bruises ___Other? ________ Seatbelt in use? ( ) Yes ( ) No

Was your head above or below the headrest? __________________ Did Air Bag Deploy? _________________

What was the damage to your car? $ ____

ON-THE-JOB INJURY

How did the injury occur? ____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: _________________________ Address: ____

OTHER

Describe the circumstances of the accident (Be Specific) ____

____

* *

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Did you require post-accident hospitalization? ( ) Yes ( ) No X-Rays? ( ) Yes ( ) No

Name of Hospital or Emergency ________________________________Date ____________________________

Have you lost any days of work? ( ) Yes ( ) No If Yes, _________ through _______________________________

INSURANCE INFORMATION

Your Insurance Company ___________________________Address___________________________________

Other Party's Name________________________________Address___________________________________

Other Party's Ins. Co._______________________________Address___________________________________

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjuster______________________________Company_________________________________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name______________________________Address___________________________________

Signature: ____________________________________

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____________________ Date ____________________ **Age**____________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

Neck Disability Index

Date: __________________ Patient Name: ____ Patient # _____________

Please read instructions;

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

SECTION 1-PAIN INTENSITY

- **A.** I have no pain at the moment.
- **B.** The pain is very mild at the moment.
- **C.** The pain is moderate at the moment.
- **D.** The pain is fairly severe at the moment.
- **E.** The pain is very severe at the moment.
- **F.** The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing Dressing, etc)

- **A.** I can look after myself normally, without causing extra pain.
- **B.** I can look after myself normally, but it causes extra pain.
- **C.** It is painful to look after myself and I am slow and careful.
- **D.** I need some help, but manage most of my personal care.
- **E.** I need help every day in most aspects of self care.
- **F.** I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- **A.** I can lift heavy weights without extra pain.
- **B.** I can lift heavy weights, but it gives extra pain.
- **C.** Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- **D.** Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- **E.** I can lift very light weights.
- **F.** I cannot lift or carry anything at all.

SECTION 4-READING

- **A.** I can read as much as I want to, with no pain in my neck.
- **B.** I can read as much as I want to, with slight pain in my neck.
- **C.** I can read as much as I want to, with moderate pain in my neck.
- **D.** I can't read as much as I want, because of moderate pain in my neck.
- **E.** I can hardly read at all, because of severe pain in my neck.
- **F.** I cannot read at all.

SECTION 5-HEADACHES

- **A.** I have no headaches at all.
- **B.** I have slight headaches that come infrequently.
- **C.** I have moderate headaches that come infrequently.
- **D.** I have moderate headaches that come frequently.
- **E.** I have severe headaches that come frequently.
- **F.** I have headaches almost all the time.

SECTION 6-CONCENTRATION

- **A.** I can concentrate fully when I want to, with no difficulty.
- **B.** I can concentrate fully when I want to, with slight difficulty.
- **C.** I have a fair degree of difficulty in concentrating when I want to.
- **D.** I have a lot of difficulty in concentrating when I want to.
- **E.** I have a great deal of difficulty in concentrating when I want to.
- **F.** I cannot concentrate at all.

SECTION 7-WORK

- **A.** I can as much work as I want to.
- **B.** I can do my usual work, but no more.
- **C.** I can do most of my usual work, but no more.
- **D.** I cannot do my usual work.
- **E.** I can hardly do any work at all.
- **F.** I cannot do any work at all.

SECTION 8- DRIVING

- **A.** I can drive my car without any neck pain.
- **B.** I can drive my car as long as I want, with slight pain in my neck.
- **C.** I can drive my car as long as I want, with moderate pain in my neck.
- **D.** I can't drive my car as long as I want, because of moderate pain in my neck.
- **E.** I can hardly drive at all, because of severe pain in my neck.
- **F.** I can't drive my car at all.

SECTION 9-SLEEPING

- **A.** I have no trouble sleeping.
- **B.** My sleep is slightly disturbed (less than 1 hr sleepless)
- **C.** My sleep is mildly disturbed (1-2 hrs sleepless).
- **D.** My sleep is moderately disturbed (2-3 hrs sleepless).
- **E.** My sleep is greatly disturbed (3-5 hrs sleepless).
- **F.** My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- **A.** I am able to engage in all my recreation activities, with no neck pain at all.
- **B.** I am able to engage in all my recreation activities, with some neck pain.
- **C.** I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- **D.** I am able to engage in a few of my recreation activities, because of pain in my neck
- **E.** I can hardly do any recreation activities, because of pain in my neck.
- **F.** I can't do any recreation activities at all.

Patients Signature _________________________________ Date __________

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-25% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-40% is moderate; 50-68% is severe; 72% or more is complex.

Name: ________________________

Date: ____________________
Patient #: ________________

Oswestry Low Back Functional Rating

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please, just, circle the one choice which best describes your problem right now.**

Section 1—Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2—Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

Section 3—Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
E. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

Section 4—Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5—Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Patient Signature ________________________________

DISABILITY INDEX SCORE: % ______________________

Section 6—Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it immediately increases the pain.

Section 7—Sleeping
A. I get no pain in bed.
B. I get some pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8—Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases my degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interactions, e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

Section 9—Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

Section 10—Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

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

Name: ________________________________Date: ______________
Print patients 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)

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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 a 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 a patient and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to a 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, a 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 Fred B. Phillips, D.C. 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 Fred B. Phillips, D.C.

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.

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INFORMED CONSENT FOR TREATMENT

PATIENT NAME ________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

__spinal manipulation therapy	__palpation	__vital signs
__range of motion testing	__orthopedic testing	__basic neurological testing
__muscle strength testing	__postural analysis	__EMS
__radiographic studies	__hot-cold therapy	__other (please explain)

____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest,
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers,
- Hospitalization,
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the information of adhesions and reduce mobility when may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Fred B. Phillips and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ___________ **Patient’s Name** _____________________________ **Patient‘s signature** ___________________________

Date: ___________ **Signature of Parent or Guardian (if a minor)** _____________________________________

Date: ___________ **Doctor’s Name:** **Fred B. Phillips, D.C.**__________ **Doctor’s Signature:** ________________________

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X-RAY STATEMENT

Date_______________

Please complete and sign this statement regarding your x-ray examination.

IT IS VERY IMPORTANT YOU ARE NOT PREGNANT.

Date of last period:____

Type of birth control method being used if any: ________________________________

List any surgical procedure performed that prevent you from becoming pregnant:

____

Print Patients Name: ____

Patients Signature: ____

Signature of Guardian for the Minor Patient: __________________________________

Patient's Birth date: ____

Patient's Social Security #: ____

Witness: ____

Phillips Chiropractic

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PhillipsChiro.com ~ 4010 NW Cache Road ~ Lawton, OK 73505 ~ 580-357-8688

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning Phillips Chiropractic's patient financial policy.

Prompt payment, allows us to control costs. Outstanding accounts cost both of us time and money: therefore, all patients will be required to establish financial arrangements for payment of their accounts.

Worker's compensation patients: As long as your care is determined to be W/C there is no financial responsibility due from you. However, if your claim is controverted or denied the balance will be your responsibility and the financial policy will apply to your account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. As a courtesy our practice will bill your insurance carrier. After 90 days it will then be your responsibility to remit payment for any unpaid claims by your carrier as well as any and all charges not covered by your carrier.

All copays, deductibles, and patient co-insurances are due at the time of service.

Our office does accept third party liability, however, if the third party insurance does not pay it is the patient's responsibility.

If your carrier requires Authorization our office will be happy to assist you in this process however, ultimately this is your responsibility.

Each month you will receive a monthly statement for services which are due and payable within 10 days.

All patients refusing to remit payment after the 10 days have passed; will force us to limit their future credit until the previous balance is paid in full. All patients will be required to sign a written legal agreement with our practice. All accounts are subject to be forwarded to a collection agency and credit bureau as well as all additional costs occurred in collecting the debt.

All returned check for non-sufficient funds will be subjected to a $40.00 fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact us immediately.

______________________________ _________________________

Patient's Name Date

______________________________ _________________________

Guardian Signature Date

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Phone: 580-357-8688 ~ Fax: 580-357-7483

Dear Accident Patient,

You are about to begin chiropractic care for injuries relating to a motor vehicle collision or other personal injury accident. At Phillips Chiropractic, we do everything possible to see that you receive the highest quality of care, as well as assist you in processing insurance claims most efficiently. Unlike many physicians' offices, we do not demand payment at the time of service; we accept assignment, not consignment, until settlement of your claim. Only you, the patient, have a contractual agreement with the insurance company; we do not. This is why your cooperation is so important. Your case, including settlement with insurance companies, is your responsibility. We will gladly help however we are able.

Office Policy

In order for our office to accept your case on assignment (meaning payments from insurance or a legal settlement are transferred to pay for treatment so you do not have to pay out of your own pocket, at the time of service), we must ask that you sign any and/or all of the following forms that apply:

1. Automobile Insurance Health Coverage or Med Pay – This often offers 100% coverage (no deductible) in the event that the claim is related to the accident. Claims on this portion DO NOT increase your premium. Your insurance agent can tell you if you have this type of coverage.

2. Any Major Medical Coverage (Group or Private) – This will provide payment as you are treated and will be subrogated upon settlement with the third party.

3. A Physician's Lien – Liens will be filed with the courthouse for each vehicle or accident policy. Copies of the liens will be mailed to all insurance companies involved, to the patient, and to the attorney, if applicable.

As you can see, we are requesting payment from all potential sources. We can only collect once for our services, so any excess funds that might result from your case are immediately refunded directly to you, the patient, in compliance with state laws.

I, ____________________________, have read and understand the requirements to become a Motor Vehicle Collision or Personal Injury Patient. I fully understand that it is my responsibility to disclose any insurance coverage of the above mentioned variety. I agree to assist in the filing of claims, for my health care charges. I realize that failure to disclose and/or assist with the filing of these claims will result in my entire balance being due immediately. I understand Dr. Phillips is accepting my case on assignment as long as I follow the prescribed treatment.

I understand that I am responsible for any and all charges for services rendered.

____________________________________	____________________________
Patient's Signature	Date
____________________________________	____________________________
CA's Signature	Date

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Name of Patient ____ Date ______________

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If you experience pain between scheduled visits, contact the clinic at 357-8688 during office hours.

I have read and understand the instructions given for my follow-up care.

____ ____________________
Patient's Signature Date