HIPAA NOTICE OF PRIVACY PRACTICES

LIVINGSTON COUNTY CHIROPRACTIC CENTER
402 NORTH PLUM STREET
PONTIAC, IL 61764
815-844-4631

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in the reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in our best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____Date_____

WELCOME

one

ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

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REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

PLEASE CONTINUE ON BACK

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IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: _____/_____/_____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ Yes ❑ No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ❑ CASH ❑ Check

_____ / _____

❑ Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

NAME: _____ **DATE:** _____

PAIN INTENSITY SCALE: ABSENT = 0 EXTREME=10

REVISED OSWESTRY PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your 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 MOST CLOSELY 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 gives extra pain.
C. Pain prevents me from lifting heavy off the floor, but I can manage if they are conveniently positioned.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can only lift light weights, at the most.
F. I cannot lift or carry anything at all.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a cane or 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 siting more than 1 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.

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 longer than 1 hour without increasing pain.
D. I cannot stand longer than ½ hour without increasing pain.
E. I cannot stand longer than 10 minutes without increasing pain.
F. I avoid standing because it increases the pain right away.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of my pain, my normal night's sleep is reduced by less than one quarter.
D. Because of my pain, my normal night's sleep is reduced by less than one half.
E. Because of my 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 the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, dancing, golfing, running, biking, 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 those that are 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.

NAME: _____ **DATE:** _____

NECK DISABILITY INDEX

PLEASE READ: This questionnaire has been designed to give us 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 that applies to you.** We realize you may consider that two or more 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 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 can 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 lifting heavy weights off the floor, but
D. I can manage if they are conveniently placed, for example of a table
E. Pain prevents me from lifting heavy weights, but I can manage
F. light to medium weights if they are conveniently positioned
G. I can only lift very light weights
H. I cannot lift or carry anything

Section 4 - Reading

A. I can read as much as I want to with no pain I 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 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 my neck
F. I cannot read at all

Section 5 – Headaches

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

Section 6 – Concentration

A. I can concentrate fully when I want to with no difficult
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 do as much work as I want to
B. I can only do my usual work, but no more
C. I can do most of my usual work, but no more
D. I cannot do mu usual work
E. I can hardly do any work at all
F. I can't 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 hours 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 pain in my neck
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 usual 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

Pain Drawing

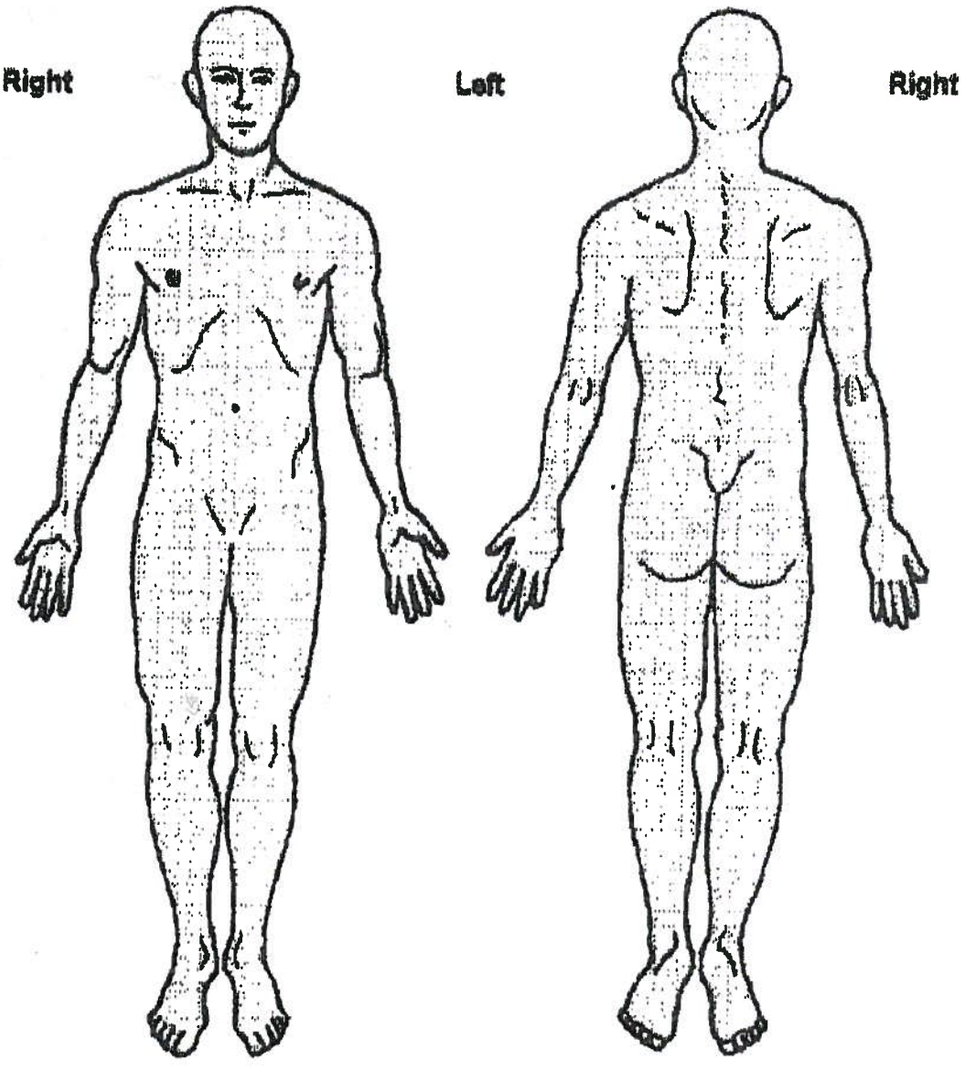
SOME PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 extreme pain).

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No Pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide

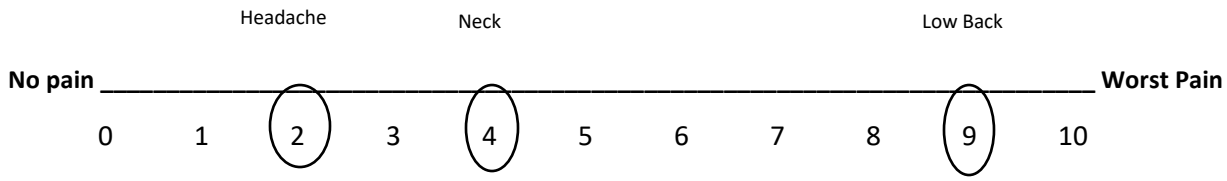


QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have **MORE** than one complaint, please answer **EACH** question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

EXAMPLE:



1. **What is your pain RIGHT NOW?**

No pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**

No pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

No pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is it at its best? _____%

4. **What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

No pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

NAME _____ AGE _____ DATE _____ SCORE_____

SCORE: #1 _____ + #2_____ + #4 _____ = _____ / 3 X 10 = _____ (Low intensity = <50; High intensity = >50)

Lifestyle Questionnaire

Name:_____ **Date:**_____

1. Are you happy with your current weight?
   Yes No

2. Do you feel your weight affects your condition? Yes No

3. Do you feel like your weight restricts you on a daily basis (i.e. walking, stairs, changing positions, getting off of the floor, etc.)? Yes No

If yes, explain:

_____

_____

_____

4. If there was an option to lose weight and change your lifestyle, how interested would you be?

_____

_____

_____

Current Medications:

_____

_____

_____

_____

_____

_____

_____

_____

Current Vitamins:

_____

_____

_____

_____

_____

_____

_____

_____