5th Street Chiropractic

5602 East 5th Street
Tucson, AZ 85711

office 520-747-2724
fax 520-747-5845

HIPAA NOTICE OF PRIVACY PRACTICES

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.

I. 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 health care 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 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, as necessary, 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 as 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 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 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 compiled in 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 this 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 your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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 your 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 and 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 individual 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 _____

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapist who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues, I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissue. Physical therapy and exercises may also be used. Although spinal manipulation/adjustments is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

SORENESS: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

DIZZINESS: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

FRACTURES/JOINT INJURY: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

STROKE: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

PHYSICAL THERAPY BURNS: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complications from treatment and I freely assume these risks.

TREATMENTS RESULTS: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter medications, exercise and possible surgery.

MEDICATIONS: Medications can be used to reduce pain or inflammation. I am aware that long term use or over use of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

SURGERY: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recover.

REST/EXERCISE: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____

Patient Signature

_____

Witness Signature

_____

Date

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INSURANCE VERIFICATION

PLEASE CALL YOUR INSURANCE CARRIER AND VERIFY YOUR COVERAGE PRIOR TO YOUR VISIT WITH US.

Patient Name _____ DOB: _____

Insurance Company _____ Phone: _____

Mailing Address _____

ID# _____ Group# _____

IN Network _____ OUT of Network _____

Chiropractic Coverage: YES _____ NO _____ Effective Date _____

Visits per Year _____ Jan-Dec _____

Referral Needed: YES _____ NO _____

Deductible: YES _____ NO _____ Amount _____ Met to Date _____

Co/Pay _____ Co Insurance _____

Physical Therapy: YES _____ NO _____ Exams: YES _____ NO _____

X-Rays: YES _____ NO _____

Notes _____

_____

_____

Date: _____ Person spoken with: _____

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VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ❒ a.m. ❒ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ❒ Driver ❒ Front Passenger ❒ Rear Passenger ❒ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ❒ Wet ❒ Dry ❒ Icy ❒ Other

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were wearing a seatbelt? ❒ Yes ❒ No

If yes, what type? ❒ Lap ❒ Shoulder

Was the vehicle equippped with airbags? ❒ Yes ❒ No

If yes, did it/they inflate properly? ❒ Right ❒ Left

Did your seat have a headrest? ❒ Yes ❒ No

If yes, what was the position of the headrest?

❒ Low ❒ Midposition ❒ High

IMPACT

Did your car impact another vehicle? ❒ Yes ❒ No

Did your car impact a structure? ❒ Yes ❒ No

If yes, explain _____

_____

Did any part of your body strike anything in the verhicle?

❒ Yes ❒ No If yes, explain _____

Was impact from:

❒ Front ❒ Rear ❒ Left ❒ Right ❒ Other _____

At the time of impact were you:

❒ Looking straight ahead ❒ Looking to the right

❒ Looking to the left ❒ Looking down

❒ Looking up

Were both hands on the steering wheel? ❒ Yes ❒ No

If no, which hand was on the wheel? ❒ Right ❒ Left

Was your foot on the brake? ❒ Yes ❒ No

If yes, which foot was on the brake? ❒ Right ❒ Left

Were you: ❒ Surprised by impact ❒ Braced for impact

OTHER VEHICLE (if applicable)

Make and model of the other vehicle _____

What direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ❒ Yes ❒ No

Were there any witnesses? ❒ Yes ❒ No

Was a police report filed? ❒ Yes ❒ No

Was a traffic violation issued? ❒ Yes ❒ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ❒ Yes ❒ No If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ❒ Yes ❒ No

When did you go? ❒ Immediately after accident ❒ Next day ❒ 2 days or more after the accident

How did you get to the hospital? ❒ Ambulance ❒ Private transportation

Name of hospital_____ Name of doctor _____

Diagnosis _____

_____

Treatment received _____

X-rays taken _____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ❒ Yes ❒ No How many work days have you missed? _____

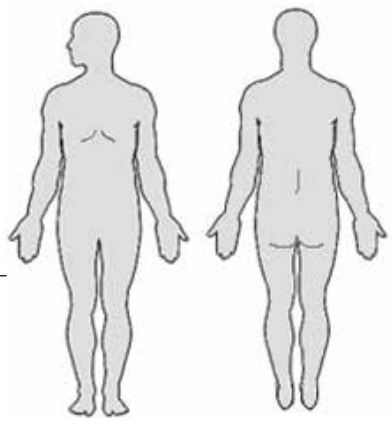
Prior to the injury were you abl eto work on an equal basis with others your age? ❒ Yes ❒ No

If you have had any of the following symptoms since your injury, please check:

- ❒ Arm/shoulder pain
- ❒ Back pain
- ❒ Back stiffness
- ❒ Chest pain
- ❒ Dizziness
- ❒ Ear buzzing
- ❒ Ear rining
- ❒ Fatigue
- ❒ Feet/toe numbness
- ❒ Hand/finger numbness
- ❒ Headaches
- ❒ Irritability
- ❒ Jaw problems
- ❒ Leg pain
- ❒ Memory loss
- ❒ Nausea
- ❒ Neck pain
- ❒ Neck stiff
- ❒ Shortness of breath
- ❒ Sleep difficulty
- ❒ Stomach upset
- ❒ Tension
- ❒ Vision blurred

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

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



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

Type of pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness
❒ Aching ❒ Shotting ❒ Burning ❒ Tingling
❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Recreation

Movents that are painful to perform: ❒ Sitting ❒ Standing ❒ Walking
❒ Bending ❒ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Gardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

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PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____ ❒ Male ❒ Female

Address: _____ City: _____ State: _____ Zip: _____

Home# _____ Work# _____ Cell# _____

Social Security # _____ Drivers License # _____

Chose one: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated Number of Children _____

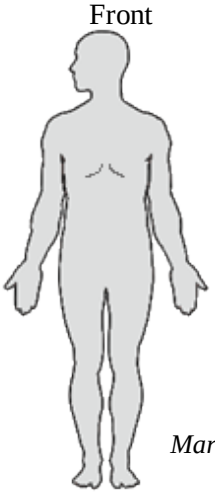
Spouse Name: _____ Contact # _____

Emergency Contact Name: _____ Contact # _____

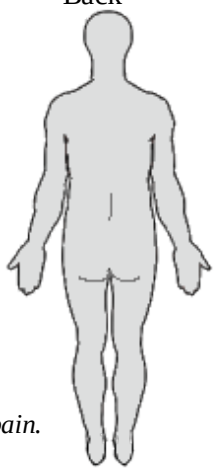
Who is responsible for your bill?

- ❒ Myself – No Insurance
- ❒ Myself and my Personal Insurance
- ❒ Auto Insurance
- ❒ Workers Comp Insurance
- ❒ Third Party Insurance

Front



Back



Mark where you feel your pain.

What is your condition? _____

Have you seen another Doctor for this condition? _____

Types of treatment _____

Results from these treatments _____

When did this condition begin? _____ Has it occurred before? _____

Is this condition: ❒ Job Related ❒ Auto Accident ❒ Home Injury ❒ Fall ❒ Sports ❒ N/A

Please list all medications you currently use _____

_____

Do you wear a shoe lift? ❒ Yes ❒ No

Do you suffer from any condition other than which you are consulting us? _____

_____

PAST HEALTH HISTORY

Major Surgery/Operations _____

Broken Bones_____

Hospitalizations _____

Major Accidents and Falls _____

Mark all that apply: ❒ Appendectomy ❒ Tonsillectomy ❒ Gall Bladder ❒ Hernia ❒ Back Surgery

Previous Chiropractic care (Date/Doctor) _____

Why chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of their pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending a treatment program for you.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

❒ Relief Care ❒ Corrective Care ❒ The Doctor may decide the appropriate care for my condition

	
Relief Care: Relief care is necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that is getting wet from a leak but not fixing the leak.	**Corrective Care:** The goal for corrective care is, while relieving the symptoms, to correct the cause of the problem. This varies in its length of treatment time, but is longer lasting.

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for the examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Doctor will not be held responsible for any pre-existing diagnosed conditions, nor for any medical diagnosis.

Patient Signature _____Date _____

Guardian/Spouses Signature authorizing care _____

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ADVANTAGE RADIOLOGY SERVICE

(419) 269-2140 (800) 442-1202

PATIENT _____ CLINIC I58 FILM DATE _____

AGE _____ SEX M ❒ F ❒ SOCIAL SECURITY # ____ / ____ / ____ DATE OF BIRTH _____

PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Worker's Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE _____ DATE _____

WITNESS _____

PATIENT HISTORY

PATIENT PRESENTATION _____

_____

TRAUMA? YES ❒ NO ❒ EXPLAIN _____

_____

PAST PERSONAL HISTORY _____

_____

MALIGNANCY? YES ❒ NO ❒ DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____