

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.



Terms of Acceptance

Patient Name: _____

Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the text below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at The Ohio State Chiropractic Association, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only: PLEASE CHECK ONE - To the best of my knowledge I am I am NOT pregnant and give my permission I do NOT give permission to x-ray me for diagnostic interpretation.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes No

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____



Confidential Patient Information

Date: _____

Patients Name: _____

Chief Complaint: _____

Address: _____

Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes No

Family Physician: _____ (Note: May we send your health information to this provider Y N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y N Have you ever had any Hip or Knee Replacements Y N

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin ____ Cholesterol Meds ____

Blood Pressure Meds ____ Muscle Relaxers ____ Birth Control ____ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to The Ohio State Chiropractic Association all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date