ReNew Chiropractic
Notice of Privacy Practices for Protected Health Information
Effective Date: October 1st, 2011

<u>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!</u>

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes:

<u>Treatment, Payment, and Health Care Options:</u>

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes physical examination, scheduling other exams or appointments with other providers, physician to physician discussion for coordination of care, and physician to staff discussion for coordination of care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our practice on a daily basis. The functions include, the entire staff having access to your file to obtain authorization of medical procedures, filing of paperwork, recording phone messages or vital from your visit, confirming your appointment with our office, scheduling your appointment with our office, obtaining the medical complaint for your visit, and dictating notes to an outside source of your visit.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any given time. You will then be required to review and resign acknowledging the changes and consenting to the changes.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office/hospital;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.
- Elect to opt out of receiving further fundraising communications from the office/hospital.

If you want to exercise any of the above rights, please contact Dr. Schulz at 1 Cottage St., Pepperell, Ma, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Donna Schulz at (978) 433-8888.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Donna Schulz. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose contact information is:
Peter Chan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Government Center
J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203
Voice phone(617)565-1340
FAX (617)565-3809
TDD (617)565-1343
http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

Name of Patient: ____

Patient Date of Birth: _______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of [insert date].

___________________________________ _____________________

Signature of Patient/Patient Representative Date

____

Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  ____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  ____

Signature of Employee Completing the Form: ____________________________________

Date Signed: ____________________

Patient Intake Form

-Confidential Patient Data-

PATIENT INFORMATION

Today's Date: ______________________

Name: ____________________________________ Date of Birth: __________

Address: ___________________________ City: _______________ State: _______

Zip: _______________

Home Phone: ____________________ Work Phone: __________________

Email: ____

Age: ______ ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other _________

Name of Spouse or Nearest Relative: ______________________ Phone: ______________

Your Occupation________________________ Your Employer: ____________________

Date of Last Physical: ____________ Name Primary Care Physician__________________

Referred to this Office by: ❑ Friend/Family Member - Name? _______________________

❑ Facebook ❑ Website ❑Other__________________

❑ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never

Payment for Services will be by: ❑ Cash ❑ Check ❑ Credit Card ❑ Health Insurance ❑ Automobile Insurance ❑ Worker's Compensation

Insurance Information: *please hand in your insurance card for photocopy purposes*

Name of Primary Insurance Company_______________________

Insured's Employer: ___________________________

Subscriber____

ID#__________________Group#____________________Effective Date____________

Insured's Social Security #:__________________ Employer's Phone #:_________

Are you covered by more than one insurance company? ❑Yes ❑No

Name of Secondary Insurance Company_______________________

Insured's Employer: _____________________________________

Subscriber:____

ID#__________________Group#____________________Effective Date____________

Insured's Social Security #:__________________ Employer's Phone #:_________

ReNew Chiropractic

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S M F
❑❑❑AIDS
❑❑❑anemia
❑❑❑arthritis
❑❑❑asthma
❑❑❑back pain
❑❑❑bladder trouble
❑❑❑bone fracture
❑❑❑bowel control loss
❑❑❑cancer
❑❑❑chest pain
❑❑❑concussion
❑❑❑convulsions
❑❑❑diabetes
❑❑❑indigestion

S M F
❑❑❑dislocated joints
❑❑❑epilepsy
❑❑❑German measles
❑❑❑headaches
❑❑❑heart trouble
❑❑❑reproductive disorder
❑❑❑hepatitis
❑❑❑high blood pressure
❑❑❑HIV/ARC
❑❑❑neck pain
❑❑❑nervousness
❑❑❑numbness
❑❑❑polio

S M F
❑❑❑poor circulation
❑❑❑kidney disorder
❑❑❑rheumatic fever
❑❑❑serious injury
❑❑❑menstrual cramps
❑❑❑sinus trouble
❑❑❑multiple sclerosis
❑❑❑muscular dystrophy
❑❑❑rheumatism
❑❑❑scarlet fever
❑❑❑tuberculosis
❑❑❑venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition_______________________________________ Date of Last Physical Exam__________

SURGICAL HISTORY:
1.____ Date:________________
2.____ Date:________________
3.____ Date:________________

Have you ever had a metal implant? ❑Yes ❑No
ACCIDENT HISTORY :
❑Job ❑Auto ❑Other 1. ___________________________Date:________________
❑Job ❑Auto ❑Other 2.____________________________Date:________________
❑Job ❑Auto ❑Other 3.____________________________Date:________________

PLEASE DESCRIBE YOUR PRESENT MAJOR COMPLAINTS

Please list your symptoms (problems):

Symptom 1.____

When did you first notice this symptom? ____

How did this symptom start? ____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: ___________________
PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

Any other activities/positions that relieve your symptoms ____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

Any other activities/positions that aggravate your symptoms ____

Please indicate the location of your symptom/pain____

Please describe your symptom (burning, achy, sharp, boring, etc.) ____

Does the symptom travel or radiate to any other part of your body? _______________________________________

If so, please describe ____

Please rate the severity of your symptom on a scale of **0-10** where 0=no pain and 10=the worst pain imaginable

Is your pain constant or does it come and go? ____

Has your pain INCREASED, DECREASED or STAYED THE SAME since it began? ___________________________

Please rate the amount of awake time you experience your symptoms (0-100%) ___________________________

Do you feel the pain more at a particular time of day? ____

Have you ever had this problem/complaint before? ____

Please Explain ____

Symptom 2____

When did you first notice this symptom? ____

How did this symptom start? ____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: ___________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

Any other activities/positions that relieve your symptoms ____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

Any other activities/positions that aggravate your symptoms ____

Please indicate the location of your symptom ____

Please describe your symptom (burning, achy, sharp, boring, etc.) _______________________________________

Does the symptom travel or radiate to any other part of your body? _______________________________________

If so, please describe ____

Please rate the severity of your symptom on a scale of 0-10 where 0=no pain and 10=the worst pain imaginable

Is your pain constant or does it come and go? ____

Has your pain INCREASED, DECREASED or STAYED THE SAME since it began? ______________________________

Please rate the amount of awake time you experience your symptoms (0-100%) ______________________________

Do you feel the pain more at a particular time of day? ____

Have you ever had this problem/complaint before? ____

Please Explain ____

Symptom 3 ____

When did you first notice this symptom? ____

How did this symptom start? ____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: ____________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

Any other activities/positions that relieve your symptoms ____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

Any other activities/positions that aggravate your symptoms ____

Please indicate the location of your symptom____

Please describe your symptom (burning, achy, sharp, boring, etc.) ____

Does the symptom travel or radiate to any other part of your body? ______________________________________

If so, please describe ____

Please rate the severity of your symptom on a scale of 0-10 where 0=no pain and 10=the worst pain imaginable

Is your pain constant or does it come and go? ____

Has your pain INCREASED, DECREASED or STAYED THE SAME since it began? ______________________________

Please rate the amount of awake time you experience your symptoms (0-100%) ______________________________

Do you feel the pain more at a particular time of day? ____

Have you ever had this problem/complaint before? ____

Please Explain ____

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IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR SYMPTOMS?
____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
____

PLEASE CHECK ANY **ADDITIONALSYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation ❑depression/weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset ❑chest pain ❑severe vision changes ❑vomiting ❑inability to control bowel/bladder ❑sudden unexplained weight loss

DO YOU HAVE ANY MEDICATION ALLERGIES? ❑NO ❑YES

MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS
MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS
MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS

ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES

MEDICATION NAME	CONDITION	DOSAGE (i.e. 2mg, puff, etc)	TIMES PER DAY
MEDICATION NAME	CONDITION	DOSAGE (i.e. 2mg, puff, etc)	TIMES PER DAY
MEDICATION NAME	CONDITION	DOSAGE (i.e. 2mg, puff, etc)	TIMES PER DAY
MEDICATION NAME	CONDITION	DOSAGE (i.e. 2mg, puff, etc)	TIMES PER DAY

ARE YOU TAKING ANY VITAMINS? ❑NO ❑YES
WHAT KIND?
____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD____________

Patient's Signature:____________________________________ Date:______________________

Financial Policy

Insurance Coverage

Welcome to ***ReNew Chiropractic***. Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Coverage for chiropractic services varies from plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our office will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations. Co-payments will be expected at time of your visit.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)
A______ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.
B______ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.
Health Insurance: (please initial)
C______I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment. Benefits may be considered out of network.

Missed Appointments

It is the policy *of **ReNew Chiropractic*** to assess a $25 missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.
________ My initials here indicate that I understand the above missed appointment policy.

Payment Plans

It is the policy *of **ReNew Chiropractic*** to discuss a payment plan, if requested, to assist with payment of any balances that is your responsibility. This requires a meeting with Rodney Schulz to review your situation and what payment amount will be mutually agreeable. Proper paperwork and authorization is necessary to enter into this arrangement.
________ My initials here indicate that I understand the above payment plans policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

______________________________ ______________________________
Signature Date