

Cancellation Policy

We do require a 24 hour cancellation notice for Chiropractic and Massage appointments. If cancelling, it must be done prior to 24 hours of your appointment to avoid being charged. Appointments that are not cancelled prior to the 24 hour period will be billed at \$80.00 for Chiropractic and \$120.00 for Massage.

Thank you in advance for your cooperation.

Patient's name (printed)

Date of birth

Patient Signature

Date

Office Staff Signature

Date

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. The examination will consist of range of motion, orthopedic testing, palpation, and basic neurological testing. During treatment, the doctor will use his/her hands or a mechanical device in order to move your joints. This action may create an audible “pop” or “click”, much like the sound when you crack your knuckles. Along with the sound, you may also experience a sense of movement in the joint. The doctor may also recommend procedures such as hot or cold packs, electrical muscle stim, traction, or exercise to enhance your response to treatment.

Anticipated Benefits of Chiropractic Treatment: Many or most patients will feel improvements in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risks of Chiropractic Treatment: As with any health care procedures, there are some complications that may arise following a chiropractic manipulation and/or therapy. A small number of patients may experience stiffness, soreness, or bruising following the first few treatments. Less likely complications could include muscle strain, ligament sprain, fracture, joint dislocation, disc, nerve, or spinal cord damage. There has been much debate and research over the association of chiropractic care and occurrence of stroke and arterial dissection. The latest scientific evidence does not establish a causal relationship but rather an association. An extremely small percentage of patients presenting to either a medical or chiropractic physician with head and neck pain, may be in early stages of a stroke. Unfortunately, there is no recognized screening procedure to identify these patients.

Other Treatment Options for the Musculoskeletal conditions:

1. Over-the-counter medication. Risks of these medications could include irritation of the stomach, kidneys, and liver.
2. Medical care anti-inflammatory drugs, pain killers, muscle relaxers, and steroids. The uses of these prescription drugs include all above side effects plus the dependence of the prescription drugs.
3. Hospitalization used with medical care includes all of the above risks, but also the additional risk of medical error, infection, or other complications.
4. Surgery with medical care includes all above risks, with the added risk of adverse reaction to anesthesia.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Patient's name (printed)

____/____/____
Date of birth

Signature of patient

Date _____

Signature of parent/guardian (if patient is a minor)

Date _____

Doctor Printed Name

Doctor Signature

Date _____

PERSONAL INJURY INTRODUCTION FORM

Today's Date: _____

Last Name:		MI:	First Name:	
Home Address:		City:	State:	Zip:
Date of Birth:	Age:	Cell phone #:		
Height:	Weight:	Cell phone carrier:		
Social Security #:		Employer's Name:		
Drivers License No:		Marital Status: Single, Married, Divorced, Widowed		
Emergency Contact:	Name:	Relationship:		
	Address:	Phone:		

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	
<input type="checkbox"/> I have coverage <input type="checkbox"/> Someone else has coverage. Indicate name of policy holder:	
How is this person related to you? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Other	
Name of your automobile insurance carrier:	
Address of your automobile insurance carrier:	
Claim Adjusters Name:	
Claim Adjusters Telephone Number:	
Claim Number:	
Do you have an insurance deductible?	<input type="checkbox"/> Yes, deductible is: \$ <input type="checkbox"/> No
Do you know your policy limits for medical bills?	<input type="checkbox"/> Yes, limit is: \$ <input type="checkbox"/> No
Have you reported this injury to your insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Did you go the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you admitted to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you went to the hospital, when did you go? <input type="checkbox"/> At the time of the accident <input type="checkbox"/> Next day	
How did you get to the hospital? <input type="checkbox"/> Ambulance <input type="checkbox"/> Police car <input type="checkbox"/> Private transportation	
Name of hospital:	Attending Doctor:

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier. **Your signature on this document indicates that you:** 1) agree to pay for any outstanding bills incurred in this office, 2) authorize the release of information necessary to secure the payment of benefits, and 3) authorize the use of this signature on all insurance submissions.

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Do you have an attorney representing you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, indicate name, address, and contact number:	Attorney Name:
	Address:
	Telephone number:

Signature of responsible party (Patient or Parent): _____ Date: _____

MOTOR VEHICLE CRASH FORM (PAGE 1)

Patient Name:	DOB:	Date:
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Date of injury:	Time of injury:	<input type="checkbox"/> AM <input type="checkbox"/> PM
City where crash occurred:	Was the street wet or dry?	<input type="checkbox"/> Wet <input type="checkbox"/> Dry
Street (location) where crash occurred:		
What is the estimated damage to your vehicle? \$		
Who made damage estimates on your vehicle?		
Who owns the vehicle you were involved in?		
Did the police come to the accident scene? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the police make a written report? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were any photographs taken of your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who took them?

DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of car crash you were involved in.

<input type="checkbox"/> Single-car crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three or more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (please describe):		

INDICATE YOUR SEATING POSITION

<input type="checkbox"/> Driver	<input type="checkbox"/> Front passenger	<input type="checkbox"/> Left rear passenger	<input type="checkbox"/> Right rear passenger
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DESCRIBE THE VEHICLE YOU WERE IN:

Model, make, and year:		
<input type="checkbox"/> Small-sized car	<input type="checkbox"/> Mid-sized car	<input type="checkbox"/> Large-sized car
<input type="checkbox"/> Pick-up truck	<input type="checkbox"/> Van	<input type="checkbox"/> Sport Utility Vehicle
<input type="checkbox"/> 2 door vehicle	<input type="checkbox"/> 4 door vehicle	<input type="checkbox"/> Large truck, bus, or semi-truck
<input type="checkbox"/> Sedan	<input type="checkbox"/> Hatchback	<input type="checkbox"/> Station wagon
<input type="checkbox"/> Other (please describe):		

DESCRIBE THE OTHER VEHICLE (if not certain, leave blank):

Model, make, and year:		<input type="checkbox"/> Unknown
<input type="checkbox"/> Small passenger	<input type="checkbox"/> Mid-sized passenger car	<input type="checkbox"/> Large-sized passenger car
<input type="checkbox"/> Van	<input type="checkbox"/> Pick-up truck/SUV	<input type="checkbox"/> Large truck, bus, or semi-truck

Patient Name: _____ DOB: _____ Date: _____

MOTOR VEHICLE CRASH FORM (PAGE 2)

AT THE TIME OF IMPACT, YOUR VEHICLE WAS:

<input type="checkbox"/> Stopped	<input type="checkbox"/> Slowing down	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Gaining speed
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AT THE TIME OF IMPACT, THE OTHER VEHICLE WAS:

<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed	<input type="checkbox"/> Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object other than car

INDICATE IF YOU BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Rood or top part of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed	<input type="checkbox"/> Other:

ALL TYPES OF COLLISIONS

Indicate those relevant to your case.

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures, such as the side door, dashboard, steering wheel, or floorboard or your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door touch your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did your body slide under the seatbelt?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle: side air bag or front air bag

MOTOR VEHICLE CRASH FORM (PAGE 3)

SEATBELT USAGE AND STERRING WHEEL HAND PLACEMENT

Indicate those relevant to your case

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and shoulder strap <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back, or shoulder?
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, indicate where each hand was positioned (use time clock face as your reference point) Left hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at _____ o'clock <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at _____ o'clock <input type="checkbox"/> Hand elsewhere

REAR-END COLLISIONS ONLY

Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:	
<input type="checkbox"/> Movable/adjustable head restraint	<input type="checkbox"/> Fixed, non-moveable head restraint
<input type="checkbox"/> No headrests in my vehicle	<input type="checkbox"/> Bench seat in your vehicle without head restraint
Please indicate how your head restraint was positioned at the time of crash (if present):	
<input type="checkbox"/> At the top of the back of your head	<input type="checkbox"/> Midway height of the back of your head
<input type="checkbox"/> Lower height of the back of your head	<input type="checkbox"/> Located at the level of your neck
<input type="checkbox"/> Level of your shoulder blades	

BRUISING AFTER THE CRASH

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black and blue) after the crash? If yes, indicate where:
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AWARENESS AND BODY POSITION DESCRIPTIONS

Check all areas that apply to you.

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending crash and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

How soon did you first notice any pain/soreness after the crash? _____

Patient Name: _____ DOB: _____ Date: _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Patient instructions: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and mark the appropriate columns for the specific symptom that applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

+ mild ++ moderate +++ severe

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	SYMPTOMS YOU HAVE CURRENTLY	SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of legs				
Pain primarily in front of thighs				
Knee pain				
Ankle/foot pain				
Other				

BEFORE AND AFTER INJURY PAIN COMPARISON FORM

For **SECTION 1**, please describe on a scale of 1-10 how intense your pain level was 2-3 months prior to this injury and indicate your current pain intensity. A **zero (0)** indicates that no symptoms exist. **1-3 pain level** is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain while doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. An **8-10 pain** level is severe and indicates that your pain intensity is to a point where you have complete inability to perform some tasks. For **SECTION 2**, please relate the percentage of time you had pain 2-3 months prior to this injury and indicate your current status in a percentage. Please fill in (circle) all shaded areas that best apply to your case.

SECTION 1. PRIOR AND CURRENT PAIN INTENSITY LEVELS

First, **SQUARE the box** following the area of pain that best indicates your overall average-usual pain severity **before** this injury. Secondly, **CIRCLE the box** that indicates your **current** usual pain intensity.

Pain Intensity	None	MINIMAL Discomfort/Ache/Stiff			SLIGHT-TO-MODERATE Hurts/Sore/Bearable Sensation				SEVERE Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid-back pain	0	1	2	3	4	5	6	7	8	9	10
Low back pain	0	1	2	3	4	5	6	7	8	9	10
Leg/foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

SECTION 2. PRIOR AND CURRENT PAIN FREQUENCY LEVELS

First, **SQUARE the box** following the area of pain that best indicates what average percentage of time you had pain **before** this injury. Secondly, **CIRCLE the box** that indicates your **current** usual pain intensity.

Pain Frequency	None	Occasional			Intermittent			Frequent	Constant		
Neck pain/Soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/hand symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/foot symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR FREQUENCY & DURATION

During the past week or since the accident/injury, if applicable (if less than one week), indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

How frequent did you have headaches 2-3 months before this injury?	_____ x week, _____ x month
How frequent do you have headaches currently?	_____ x week, _____ x month
How many hours or days did a typical headache last before this injury?	_____ hours, _____ days
How many hours or days do your typical headaches last currently?	_____ hours, _____ days
How many headache pills did you take prior to the accident typically?	_____ pills per month
How many headache pills do you take currently since the accident?	_____ pills per month

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence from first to last.

① Name of emergency room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> IME exam or consult only | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/mid back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other |

Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Made condition worse

② Name of hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> IME exam or consult only | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/mid back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other |

Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Made condition worse

③ Name of emergency room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
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| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other |

Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Made condition worse

MULTIPLE REGION FUNCTIONAL CAPACITY QUESTIONNAIRE

Patient instructions: Fill out sections 1 to 10. In each section, check one box that best applies to your current condition.

1. CURRENT PAIN INTENSITY (Check one box that best applies currently)

<input type="checkbox"/>	I currently have no pain or soreness.
<input type="checkbox"/>	My soreness/pain annoys me at work and/or at home. I am able to do all physical activity. This pain does not slow me down.
<input type="checkbox"/>	My pain is now beginning to restrict my more strenuous physical activities, such as heavy lifting. Able to perform most activities.
<input type="checkbox"/>	My pain causes some difficulty with the performance of moderate level physical activities. Unable to do more strenuous activities.
<input type="checkbox"/>	My pain makes it difficult to do average physical activity. Unable to do all heavy physical activities and some average level activities.
<input type="checkbox"/>	My pain causes significant difficulty in light physical activity. Unable to do average work. Have significant difficulty sleeping.

2. CURRENT WORK ABILITY FUNCTION (Check one box that best applies currently)

<input type="checkbox"/>	I am currently able to work full time and function normally in all job requirements with no pain or other symptoms.
<input type="checkbox"/>	I work full time and have annoying pain or other symptoms that do not slow me down or limit my ability to do all activities.
<input type="checkbox"/>	I work full time. My work output quality and/or quantity have/has been reduced 10-20% due to pain. The pain or other symptoms caused by working results in my occasionally halting work or slowing down. I require assistance at work occasionally.
<input type="checkbox"/>	I am able to work presently. I am not able to work at a normal pace beyond 2 hours and at a slower pace beyond 4 hours. My performance output quality and/or quantity is reduced by 30-60%.
<input type="checkbox"/>	I am able to work on a limited basis. I am not able to work at a normal pace for more than 30-60 minutes at a time. I can work at a slower pace with less physical activity beyond 2 hours. My ability to perform job requirements has been recently reduced by 60-90%.
<input type="checkbox"/>	I am not able to work at a normal or a slower pace. Job quality and quantity output are reduced by more than 90%. I am unable to work on a part-time status even with a flexible work schedule or job modification.

3. SPORTS, HOBBIES, AND SOCIAL ACTIVITIES (Check one box that best applies currently)

<input type="checkbox"/>	I can perform normal sports, hobbies, and social activities with my friends, family, or business acquaintances at this time.
<input type="checkbox"/>	I can perform normal sports, hobbies, and social activities, but my symptoms do occasionally slow me down.
<input type="checkbox"/>	My symptoms limit my more energetic or competitive sports, hobbies, or social activities such as dancing or running.
<input type="checkbox"/>	My symptoms limit my performance of moderate sports, hobbies, or social activities. I do not go out as often.
<input type="checkbox"/>	My symptoms limit me to only minimal sports, hobbies, and social activities.
<input type="checkbox"/>	I am unable to perform in any sports, hobbies, or social activities due to the pain or other symptoms.

4. HOME ACTIVITIES (Check one box that best applies currently)

<input type="checkbox"/>	I can perform all normal home activities such as vacuuming, cooking, cleaning, and mowing the lawn presently.
<input type="checkbox"/>	I am able to perform all normal home activities, but my symptoms occasionally slow me down.
<input type="checkbox"/>	Symptoms prohibit very strenuous home activities. I am able to do light to moderately strenuous home activities.
<input type="checkbox"/>	Symptoms limit moderate home activities. I am able to do light home activities. I sometimes need help doing activities.
<input type="checkbox"/>	I am only able to do light home activities. I am unable to vacuum, mow lawns, sweep, mop, and do laundry.
<input type="checkbox"/>	I am unable to do any home activities due to pain or other symptoms. I need help putting on my clothes.

5. SLEEPING ABILITY (Check one box that best applies currently)

<input type="checkbox"/>	I have normal sleeping patterns recently.
<input type="checkbox"/>	I have occasional difficulty sleeping due to pain or other symptoms. I wake up at night, resulting in less than 5 minutes of sleep disturbance.
<input type="checkbox"/>	I have intermittent difficulty sleeping due to symptoms. I wake up at night, resulting in 30 minutes to one hour of sleep disturbance.
<input type="checkbox"/>	I have frequent difficulty sleeping due to symptoms. I wake up at night, resulting in one to three hours of sleep disturbance. Medications help sleep.
<input type="checkbox"/>	My sleeping pattern is very restless with about 50% less sleep hours. I need medications to sleep period I frequently feel fatigued.
<input type="checkbox"/>	I have no normal sleeping hours. I am never able to sleep more than two to three hours without heavy medication. I never feel rested.

6. SITTING ACTIVITIES PRESENTLY (Check one box that best applies currently)

<input type="checkbox"/>	I can sit at my desk, terminal, chair/coach, or in my car normally with no difficulty for normal periods of time presently.
<input type="checkbox"/>	Prolonged sitting (more than 4-6 hours) will cause annoying or mild discomfort or other symptoms.
<input type="checkbox"/>	Prolonged sitting (2-4 hours) will cause pain to increase to levels that require me to change my position.
<input type="checkbox"/>	I can sit or drive for 1-2 hours, but I need frequent breaks to change my body position. I am unable to sit constantly for over 1 hour.
<input type="checkbox"/>	I cannot sit or drive for more than 30-60 minutes at a time due to pain severity.
<input type="checkbox"/>	I cannot sit at my desk, or in my chair at home, or drive my car at any time for more than 5-10 minutes due to pain severity.

MULTIPLE REGION FUNCTIONAL CAPACITY QUESTIONNAIRE

7. UPPER BODY FUNCTION (NECK, SHOULDER, ARMS, HANDS, AND UPPER BACK) (Check one box)

<input type="checkbox"/>	I am able to use my neck, upper back, shoulders, arms, and hands in all activities with no pain or other symptoms recently.
<input type="checkbox"/>	Use of my neck, upper back, shoulders, arms, and hands caused me annoying symptoms. Still able to do all activities.
<input type="checkbox"/>	I am able to move my neck, lift with my arms, reach over my head, carry objects, and grip objects with my hands. I have some difficulty with heavier lifting, or reaching objects over the level of my head. I have occasional weakness with hands. I am unable to type or use a computer keyboard for more than 3-4 hours a day.
<input type="checkbox"/>	I am able to lift my arms up to the height of my shoulder or head for short periods and carry light to moderate weight objects in hands. I am unable to type more than 1-2 hours due to pain, numbness, or tingling. I drop objects occasionally. I have to use two hands to do some tasks where I would normally use one hand. Unable to lift or carry heavy objects.
<input type="checkbox"/>	I am able to carry and grip only light objects. I get severe neck, upper back, or arm pain/symptoms when lifting any object over 1 pound over the height of my shoulder. I am unable to lift arms with any objects in my hands over the height of my head. I have difficulty gripping and grasping objects. I drop objects daily unless I am very careful. I have to use two hands for most activities that I could do with one hand before. I am unable to type for more than 5-10 minutes at a time.
<input type="checkbox"/>	I am able to lift my arms to the level of my shoulders. Lifting my arms over the height of my head causes severe pain. Every time I lift my arms or twist my upper back or neck I get severe pain and have to lower my arms or straighten my body.

8. LOWER BODY FUNCTION (LOW BACK, HIP, KNEE, LEGS AND FEET) (Check one box)

<input type="checkbox"/>	I can sit, drive, stand, squat, stoop, walk, bend, use my feet, and lift with my low back, hip, and legs with no pain presently.
<input type="checkbox"/>	I get annoying discomfort if doing prolonged (more than 6 hours) sitting, driving, walking or standing or very strenuous physical activities such as lifting, squatting, stooping, and bending.
<input type="checkbox"/>	Heavy lifting (more than 60 pounds) causes severe low back or leg pain. Able to lift light to moderate weight with little pain. Sitting, driving, walking, standing, or bending for more than 2-3 hours a day causes pain levels to increase to point where I have to stop and take a break.
<input type="checkbox"/>	I am unable to lift more than 50 pounds due to severe pain. I am able to lift 25-45 pounds with some moderate pain. Slight discomfort lifting less than 25 pounds. Sitting, driving, walking, standing, or bending for more than 1-2 hours a day causes pain levels to increase to point where I have to stop and take a break.
<input type="checkbox"/>	I am unable to lift more than 25 pounds due to severe pain. I am able to lift 10-20 pounds with some moderate pain. Slight discomfort lifting less than 5 pounds: Sitting, driving, walking, standing, or bending for more than 30 minutes a day causes pain levels to increase to point where I have to stop and take a break.
<input type="checkbox"/>	I experience severe low back or leg pain when doing any lifting or by simply bending my back or hips. I am able to walk only with the use of a cane, crutches, back brace, or by supporting myself. I need to lie down frequently to relieve pain. I am unable to lift any object. I have severe difficulty using the bathroom. I am unable to stand or walk for more than 5 minutes.

9. HEADACHES AND/OR MIGRAINE HEAD PAIN RECENTLY (Check one box that best applies currently)

<input type="checkbox"/>	I have no headaches or migraine pain recently or today.
<input type="checkbox"/>	My headache pain annoys me. I am able to work and perform all normal work/home/sport activities with the head pain.
<input type="checkbox"/>	My headaches cause me to lose up to 30 minutes of productive time at work/home each day recently.
<input type="checkbox"/>	My headaches cause me to lose 30 minutes to 2 hours of productive time at work/home each day.
<input type="checkbox"/>	My headaches cause me to lose 2-4 hours of productive time at work/home each day. Unable to do sport activities.
<input type="checkbox"/>	My headache/migraine pain makes it impossible to work, go to school, do home activities, or do recreational activities

10. MENTAL ABILITY FUNCTION (Check one box that best applies currently)

<input type="checkbox"/>	My memory and mental function are normal. I have no difficulty with work or home mental-intellectual demands recently.
<input type="checkbox"/>	I am able to perform most mental activities and am able to function at work, at home, and in society. I have occasional slight difficulty with complex tasks, memory, remembering appointments, balancing checkbook, and doing math.
<input type="checkbox"/>	I am able to function at work and home and society. I have difficulty with complex tasks, multiple tasks, and intense concentration projects. I have noticed about 10-25% memory loss and job performance decline recently.
<input type="checkbox"/>	I am not able to handle complex or multiple tasks. I have notable memory loss and difficulty making decisions. My friends and family have noticed recent personality changes. It takes much longer to do work and home tasks. I can handle one task at a time. I use a day timer to help me remember things I need to do. I have about 25-50% loss of job performance recently.
<input type="checkbox"/>	I am able to handle only one simple mental task at a time. I am unable to keep my job because of performance ratings. I have noticed 50-75% loss of memory skills and ability to perform mental skills.
<input type="checkbox"/>	I am unable to hold any job at all. I am unable to balance a checkbook and need help. I am unable to shop at a grocery store without a shopping list. I am unable to remember instructions.

Neck Disability Index

Neck
Index
Score

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Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help everyday in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights, but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.
- ⑥ I cannot lift or carry anything at all.

Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Revised Oswestry Questionnaire

Name: _____

Date: _____

INSTRUCTIONS: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but **PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Pain Intensity <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much.	Personal Care (Washing, Dressing, Etc.) <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="checkbox"/> Washing and dressing increases the pain, but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain, I am unable to do any washing or dressing without help.
Lifting <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights at the most.	Walking <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me from walking more than one mile. <input type="checkbox"/> Pain prevents me from walking more than ½ mile. <input type="checkbox"/> Pain prevents me from walking more than ¼ mile. <input type="checkbox"/> I can only walk while using a cane or on crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.
Sitting <input type="checkbox"/> I can sit in any chair as long as I like without pain. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> Pain prevents me from sitting at all.	Standing <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain while standing, but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ten minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases the pain straight away.

Sleeping	Social Life
<input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed, but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one-quarter. <input type="checkbox"/> Because of pain, my normal nights sleep is reduced by less than one-half. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than three-quarters. <input type="checkbox"/> Pain prevents me from sleeping at all.	<input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of my pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain.
Traveling	Changing Degree of Pain
<input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down.	<input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates, but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better, but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.

Patient Acknowledgement of Privacy Notice

The Notice of Privacy Policy of **Summit Chiropractic and Massage** of West Linn describes how health information about me may be used and disclosed. The following is a summary of our Notice of Privacy Policy:

Your Rights - As examples, you have the right to:

- Get a copy of the privacy notice.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a copy of your paper or electronic medical record.
- File a complaint if you believe your privacy rights have been violated.

Your Choices - You have some choices in the way that we use and share information. With your permission, we may tell family and friends about your condition.

Our Uses and Disclosures - We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Comply with the law.
- Respond to lawsuits and legal actions.

For further details, you may obtain a full copy of our Notice of Privacy Policy.

I, _____ hereby acknowledge that I have had an opportunity to review the Notice of Privacy Policy and may obtain a copy of the Notice of Privacy Policy at will from **Summit Chiropractic and Massage** of West Linn. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

I authorize the following people access to my treatment and financial information and I authorize **Summit Chiropractic and Massage** to discuss treatment and finances with them:

Name: _____	Relationship: _____
Name: _____	Relationship: _____

I authorize Summit Chiropractic and Massage to leave detailed voice messages for me ☐

_____ Patient's name (printed)	_____/_____/_____ Date of birth
_____ Signature of patient	_____ Date
_____ Signature of parent/guardian (if patient is a minor)	_____ Date

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West Linn, Oregon 97068
503-650-2487

NOTICE OF PRIVACY PRACTICES

This Notice is effective March 26, 2013

**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***

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request. Please contact our Privacy Officer at **503-650-2487** to obtain a copy of our current Notice).

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at **503-650-2487**.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you.

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For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at **503-650-2487**.

1. Treatment

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Example: Jane is a patient at the health department. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.

2. Payment

We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

Example: Jane is a patient at the health department and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The health department billing clerk will *use* medical information about Jane when he prepares a bill for the services provided at the appointment and the blood test. Medical information about Jane will be *disclosed* to her insurance company when the billing clerk sends in the bill.

Example: The nurse practitioner referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist's billing clerk may contact Jane's insurance company before the specialist runs the tests to determine whether the plan will pay for the test.

3. Healthcare Operations

We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.

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- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

Example: Jane was diagnosed with diabetes. The health department used Jane's medical information – as well as medical information from all of the other health department patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not identify any specific patients without their permission).

Example: Jane complained that she did not receive appropriate healthcare. The health department reviewed Jane's record to evaluate the quality of the care provided to Jane. The health department also discussed Jane's care with an attorney.

4. Persons Involved in Your Care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at **503-650-2487**.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

Example: Jane's husband regularly comes to the health department with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.

5. Required by Law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to

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do so by law. Below are brief descriptions of the “national priority” activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at **503-650-2487**.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as tuberculosis), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers’ compensation:** We may disclose medical information about you in order to comply with workers’ compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans’ activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorizations

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the “authorization” – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

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The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

- ☐ Uses and disclosures for marketing purposes.
- ☐ Uses and disclosures that constitute the sales of medical information about you.
- ☐ Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- ☐ Any other uses and disclosures not described in this Notice.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at **503-650-2487**.

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at **503-650-2487**.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an **Access Request Form**. Access Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Privacy Officer.

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We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

7. Right to Notification if a Breach of Your Medical Information Occurs

You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

Summit Chiropractic and Massage

22400 Suite 101 Salamo Road
West Linn, Oregon 97068
503-650-2487

- ☐ A brief description of what happened;
- ☐ A description of the health information that was involved;
- ☐ Recommended steps you can take to protect yourself from harm;
- ☐ What steps we are taking in response to the breach; and,
- ☐ Contact procedures so you can obtain further information.

8. Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

**YOU MAY FILE A COMPLAINT
ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

**Summit Chiropractic and Massage
Attention Privacy Officer
22400 Suite 101 Salamo Road
West Linn, Oregon 97068**

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

Email: OCRComplaint@hhs.gov