

# Welcome

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## Phone Numbers

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Accident Information

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

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

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

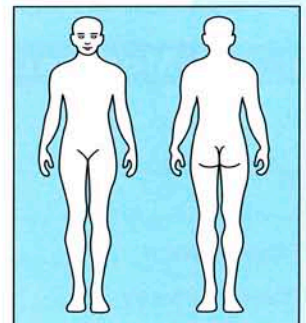
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine			Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
			Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

<p><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	<p>Packs/Day _____</p> <p>Drinks/Week _____</p> <p>Cups/Day _____</p> <p>Reason _____</p>
---	---	--	---

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

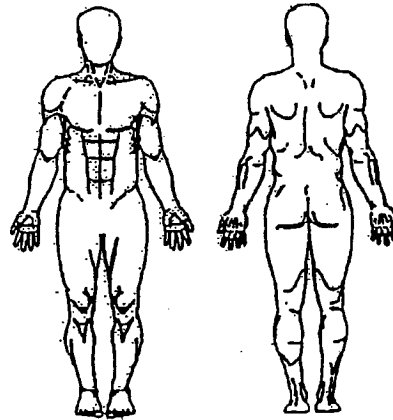
Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Job Descript \_\_\_\_\_

Please answer the following questions to the best of your ability:

1. When did your pain start? \_\_\_\_\_
2. How did your pain start? \_\_\_\_\_
3. Did you have similar pain problems before your current one? Please Explain.  
\_\_\_\_\_
4. Please describe your pain:  Constant  Intermittent  Dull  
 Throbbing  Sharp  Stabbing  Shooting  Burning
5. What aggravates your pain? \_\_\_\_\_
6. What relieves your pain? \_\_\_\_\_
7. Have you had any of the following tests done?  MRI  CT Scan  
 X-Ray  EMG  Bone Scan  Other: \_\_\_\_\_
8. Have you had any treatment(s) for your pain?  Medications  Epidural Injections  Nerve Blocks  Physical Therapy  TENS Unit  
 Acupuncture  Other: \_\_\_\_\_
9. Do you sleep well at night?  Yes  No \_\_\_\_\_ Interrupted \_\_\_\_\_ Uninterrupted  
Mark appropriate area(s) of pain with an "X"
10. Are you frustrated with the pain?  
 Yes  No
11. Are you depressed?  
 Yes  No
12. How is the stress in your life?  
 Average  Above  Below
13. Do you have suicidal thoughts?  
 Yes  No  
If yes, state last time: \_\_\_\_\_
14. Have you ever attempted suicide?  
 Yes  No
15. Do you now see or have you seen a psychiatrist/psychologist?  
 Yes  No  
If so, why? \_\_\_\_\_
16. Are you married?  
 Yes  No Number of children? \_\_\_\_\_
17. Do you smoke cigarettes?  
 Yes  No How many cigarettes per day? \_\_\_\_\_
18. Do you drink alcohol?  
 Yes  No How many drinks per day? \_\_\_\_\_
19. Do you now use or have you ever used illicit drugs?  
 Yes  No If yes, which drugs? \_\_\_\_\_
20. Do you have any problems with any of the following:  Heart  Lungs  
 Stomach/Ulcer  Kidneys  Diabetes  High Blood Pressure  Liver  
 Stroke  Other: \_\_\_\_\_



Indicate with an "x" your level of pain

0 \_\_\_\_\_ 10  
No pain \_\_\_\_\_ Worse pain

Weight Loss	Weight Gain	Fever	Chills	Rash
Itching	Blur Vision	Headache	Neck Pain	Cough
Shortness of Breath	Chest Pain	Pain On Urination	Pelvic Pain	Nausea
Vomiting	Constipation	Blood In Stools	Dark Tarry Stools	Tender Muscles
Stiff Joints	Swollen Joints	Back Pain	Numbness Arm/Legs	Numbness Legs/Feet
Weakness Arms/Hands	Dizziness	Loss of Balance	Depression	Anxiety
Poor Sleep	Other:			

21. List all previous surgeries and give approximate dates: \_\_\_\_\_

22. List all your current medications and dosages: \_\_\_\_\_

23. List all other medications tried previously for your pain: \_\_\_\_\_

24. List all medications to which you are allergic: \_\_\_\_\_

25. Are you presently working?  Yes  No

26. Are you receiving disability benefits?  Yes  No  
Workers' Compensation?  Yes  No

27. Are you currently involved in any legal action or proceeding?  Yes  No

Additional Comments: \_\_\_\_\_

**PLEASE DO NOT WRITE BELOW THIS LINE**

History:

---



---



---



---

PE: HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ Temp: \_\_\_\_\_ R: \_\_\_\_\_

---



---



---



---



---



---



---



---



---



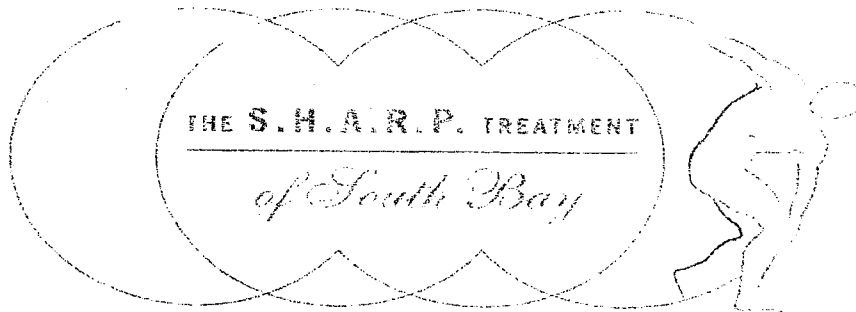
---



---



---



2557A Pacific Coast Highway Torrance, CA 90505  
Ph: 310-626-8037 • Fax: 310-626-8038

## Insurance Policies and Guidelines

The purpose of this is to let you know how our office works in the handling of your insurance claims. We do this to eliminate any questions or misunderstandings that could arise and later affect your ability to use your policies as they were intended.

We ITEMIZE all our procedures. The reason for this is to let the company personnel know exactly what was done on each visit, what was not done, and why. In reporting to insurance companies, we are responsible to them on your behalf to accurately inform them as to your condition, status, any complications, exacerbations, unusual circumstances, etc., letting them know how long we anticipate you to need our care and at what frequency. All this involves a tremendous amount of staff and professional time and expense. We do this as a service to you. All we ask for is your cooperation.

Because we itemize every procedure rather than just describe what is being done as an "office visit", the charges per visit can vary. We know there are a lot of charges that will not be paid for various reasons, such as maximum dollar amount limits per visit, procedures that the policy doesn't cover, etc., and we expect to receive denials on claims as it's the nature of the insurance industry. However, we are still going to bill for everything we do whether we get paid or not, so that we can adequately communicate with these companies.

Our experience shows that a company that receives billings that describe your visit to an office as an "adjustment" do not understand what is being done and why. Some have taken the position that billings sent in this way imply that you are haphazardly receiving adjustments without any diagnostic criteria to objectively determine if an adjustment is needed on that visit. They look on this practice in reporting the same way they would if an M.D. were to just randomly give out shots or pills to every patient without first determining whether or not that patient actually needed anything done that visit. It just isn't good practice.

Some companies pay 100%, some pay 90%, some pay 80%, some pay 50%, some pay for x-rays but not exams, some pay for exams but not x-rays, some only pay for an adjustment, some pay for everything but the adjustment. Medicare pays for approximately 12-24 visits a year demanding that x-rays be taken but not paying for them or the exams that the patient must have, and the list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

We also want you to know that what you are responsible for is your deductible and the co-pay that your policy says you must pay. If you have an 80%/20% policy, then the amount you are responsible for is the 20%. If you have a special financial situation that makes this difficult or impossible for you, you have only to speak to one of the staff and arrangements will be made so that you can receive the care you need at a fee you can afford. We cannot, however, read minds; you must tell us, then we can help you.

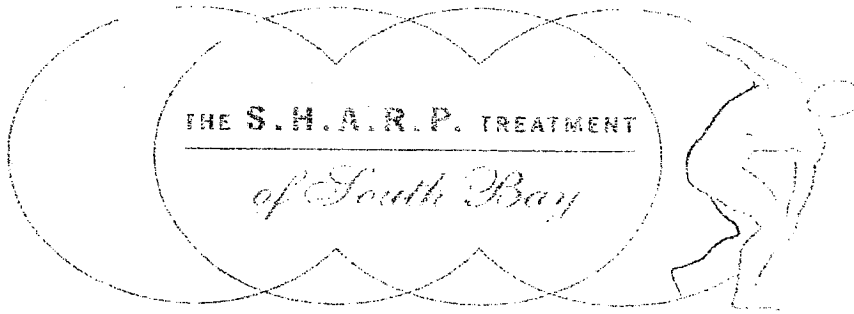
Any correspondence that you receive must be brought to us so that we may have a copy of it for your records (often the patient receives information that is vital to processing a claim that never finds its way to the doctor's office). We ask that you please help us help you by doing this.

Please understand that our purpose is to help all people, not just those who can afford it. By following the above policies, this is made possible.

Please sign your name below indicating that you have read the above and understand it. Thank you.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



## Power of Attorney to Endorse Checks

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint \_\_\_\_\_, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said doctor which checks, drafts or money orders are to pay for Medical/Chiropractic services or the like which have been made by \_\_\_\_\_, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said doctor as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands.

\_\_\_\_\_  
Patient's Full Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness to Patient's Signature

# *The S.H.A.R.P. Treatment of South Bay*

## **FINANCIAL AGREEMENT**

Date: \_\_\_\_\_

By signing below, I am acknowledging that *The S.H.A.R.P. Treatment of South Bay* may reduce their co-payments & out of pocket fee charges for my treatments due to any financial hardship that may incur.

I understand that it is purely at their discretion.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement is different from the standard at *The S.H.A.R.P. Treatment of South Bay*.

If it is my insurance company(s) policy that any and all co-payments be paid in full, then I agree that it is my responsibility to notify my insurance carrier(s) of my financial hardship and that I will only be able to make partial payments.

Patient Name (Please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witnessed By: \_\_\_\_\_

# The S.H.A.R.P. Treatment of South Bay

## Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

Insured:  
Patient:  
Employer:  
Claim / Group #  
SSN / ID #

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

The S.H.A.R.P. Treatment of South Bay  
2557-A Pacific Coast Highway  
Torrance, CA 90505  
Phone (310) 626-8037  
Fax (310) 626-8038

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

The S.H.A.R.P. Treatment of South Bay  
2557-A Pacific Coast Highway  
Torrance, CA 90505  
Phone (310) 626-8037  
Fax (310) 626-8038

the professional or medical expense benefits allowable and otherwise payable to me under my current health insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

\_\_\_\_\_  
Witness



## Notice of Privacy Practices

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

The S.H.A.R.P. Treatment of South Bay is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of your Health Information**

#### **Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The S.H.A.R.P. Treatment of South Bay”

“It is our policy to provide a substitute health care provider, authorized by The S.H.A.R.P. Treatment of South Bay to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation”

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to The S.H.A.R.P. Treatment of South Bay for healthcare services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received”

#### **Worker’s Compensation**

We may disclose your health information as necessary to comply with State Worker’s Compensation Laws.

### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or any other person responsible for your care about your medical condition or in the event of an emergency or of your death.

### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### **Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceeding.

### **Law Enforcement**

We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### **Deceased Persons**

We may disclose your health information to coroners or medical examiners.

### **Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissue.

### **Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### **Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the safety of a particular person or to the general public.

### **Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

### **Marketing**

We may contact you for marketing purposes or fundraising purposes, as describe below:  
(example)

“It is our practice to participate in charitable events to raise awareness, food, donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not

our policy to disclose any personal health information about your condition for the purpose of The S.H.A.R.P. Treatment of South Bay sponsored fund-raising events.”

#### **Change of Ownership**

In the event that The S.H.A.R.P. Treatment of South Bay is sold or merged with another organization, your health information/record will become the property of the new owner.

#### **Communication**

As a courtesy to our patients The S.H.A.R.P. Treatment of South Bay may contact you to provide appointment reminders, referral appointments, case status, health related benefits and services, or to obtain additional information to complete a referral, assist in payment collection, process billing claims, check on your injury status.

The following means of communications used by The S.H.A.R.P. Treatment of South Bay includes (not limited to): a) telephoning your home, cell phone, pager or work and leaving a message with minimal disclosure on a answering or voice mail machine or with the individual answering the phone. b) encrypted e-mail. c) postcard, letter, newsletter or other mailing at the address provided by you.

#### **Authorizations**

Uses and/or disclosures other than those described herein will be made only with your written authorization.

#### **Family/Friends/ Caregivers**

Your PHI (personal health information) may be disclosed by The S.H.A.R.P. Treatment of South Bay to any person, identified and authorized by you, whose involvement is relevant to your care or the payment of your care. The S.H.A.R.P. Treatment of South Bay may also use or disclose your PHI to notify or assist in the notifications of a family member (including identifying or locating), a personal representative or other person responsible for your care, your location, general condition or death. However, in both cases the following conditions apply:

- a) If you are present at or prior to the use or disclosure of your PHI, The S.H.A.R.P. Treatment of South Bay may use or disclose your PHI if you agree, or if The S.H.A.R.P. Treatment of South Bay can reasonably infer from the circumstances, based on the exercise of it's professional judgment that you do not object to the use or disclosure. b) If you are not present, The S.H.A.R.P. Treatment of South Bay will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement.

#### **Incidental disclosure**

**SIGN IN LOG:** The S.H.A.R.P. Treatment of South Bay maintains a sign in log for patients receiving treatment in the office. The sign in log is located in a position where staff can readily see who is seeking care, as well as the individual's location within the office. This information may be seen by, and is accessible to, others who enter the office. Logs are kept in locked storage.

**NEW PATIENT/THANK YOU/PICTURE BOARDS:** New patients names are listed on a New Patient Welcome Board posted in public view.

Patients who trust The S.H.A.R.P. Treatment of South Bay with the care of their family, friends and acquaintances will see their name on our board thanking them for their referral, our thank You Board is posted in public.

The **S.H.A.R.P.** Treatment of South Bay posts in public view a board containing photographs of patients and their family members, this board is viewed by others who enter the office.

**HOLIDAY CARDS:** Holiday Cards received by The **S.H.A.R.P.** Treatment of South Bay will be posted as decorations and will be seen by anyone who enters the office.

**PATIENT CHARTS/FILES:** The **S.H.A.R.P.** Treatment of South Bay maintains a high level of confidentiality with patients PHI, however, there may be circumstances where a closed file or chart may be on a desk, in a bin, or in a wall pocket facing a treatment door, which may incidentally disclose only a patient name, but not PHI, to an individual passing this area.

**TESTIMONIAL LETTERS:** Testimonial and thank you letters are placed in a binder located in the reception area for all to read.

**PHI SECURITY:** No unescorted unauthorized persons are allowed in the area where PHI is kept or stored, this area in the office has a sign posted as a secured Area with no Unescorted Access. This PHI area is further secured with locking file cabinets.

Computer PHI is secured with assigned personnel access codes, automatic screensaver, daily backup, virus and firewall protection along with e-mail encryption.

**DISPOSAL OF PHI:** Documents to be disposed of will be processed through a shredder before being placed in a trashed receptacle.

**SECURITY MONITORING:** The **S.H.A.R.P.** Treatment of South Bay is protected by a security system, which is monitored by a security company. This office is further protected by a security Cameras Any persons entering this facility will be recorded on surveillance tape.

#### **Appointment scheduling**

To save time we ask that you pre-schedule all of your appointments in advance. If it is necessary to reschedule your appointment we must **receive your call BEFORE** your scheduled time or it will be consider a broken appointment. Please refrain from **REPEATEDLY** rescheduling. To keep your spinal alignment progress on track, broken or rescheduled appointments must be made up by the following week.

#### **Broken appointments**

There is a **\$25.00** fee for broken (no-show) appointments (when the patient does not make the appointment and has not reschedule before the time of appointment). If the patient is more than **20 minutes late**, without having previously called, the appointment will be considered broken and a \$25 fee will be charged. If you repeatedly miss or reschedule your appointments, we will have to regretfully discharge you from care. The \$25 dollar fee is due before the patient may be rendered chiropractic care again in this office. The fee is above and beyond patient's established payment plan. If you are being rendered care on a lien bases, the fee does not apply towards the lien, but must be paid in cash by the patient.

#### **Financial agreements**

It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you can't keep your financial agreement, inform us immediately to eliminate any misunderstandings. We will make every attempt to make afford-

able arrangements. If you become delinquent with your payments, you must bring account current before new financial arrangements can be made.

#### **Interruption of care**

In the unlikely event it is necessary to discontinue your care for any reason, all outstanding fees for services already rendered become immediately due and payable.

#### **Chiropractic excellence**

In order to continue providing the best, most current chiropractic care available The S.H.A.R.P. Treatment of South Bay occasionally travels to attend conferences and continuing education seminars.

Remember that healing and spinal correction takes time. **If at any time during your care you do not feel you are responding as well as you expected, please schedule a consultation with The S.H.A.R.P. Treatment of South Bay.** We want you to get the most from your chiropractic care.

#### **Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that The S.H.A.R.P. Treatment of South Bay is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspected copy of your health information.
- You have a right to request that The S.H.A.R.P. Treatment of South Bay amend your protected health information. Please be advised, however, that The S.H.A.R.P. Treatment of South Bay is not required to agree to amend your protected health information. If you request to amend your health information has denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by The S.H.A.R.P. Treatment of South Bay.
- You have a right to a paper copy of this notice of Privacy Practices at any time upon request.

#### **Changes to this Notice of Privacy Practices**

The S.H.A.R.P. Treatment of South Bay reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, The S.H.A.R.P. Treatment of South Bay is required by law to comply with this notice.

The S.H.A.R.P. Treatment of South Bay is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about our privacy rights please contact:

#### **Complaints**

Complaints about your Privacy rights, or how The S.H.A.R.P. Treatment of South Bay has handled your health information should be directed to