

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) _____

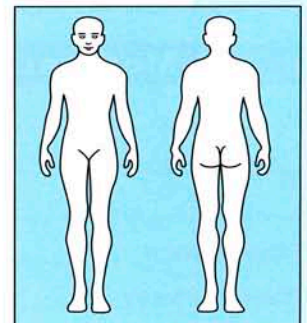
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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

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 (____) _____ | _____ | _____ |

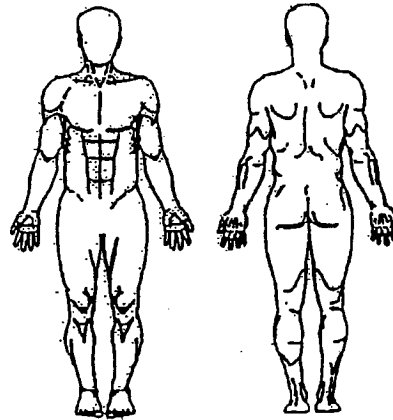
Name _____ Date _____

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

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: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of The S.H.A.R.P. Treatment of South Bay 'NOTICE OF PRIVACY PRACTICES,' revision date April 15, 2003

As required by the Privacy Regulations _____ from
Name of Staff Member

The S.H.A.R.P. Treatment of South Bay Clinic has explained the
 "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware of that The S.H.A.R.P. Treatment of South Bay has included a provision that it reserves the right to change the terms of its notice and to make the new notice of provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my protected health information.
- I wish to object to the following in the "Notice of Privacy Practices."

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices"

 Signature Date

 Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

PATIENT NAME _____ DATE _____

Circle only what applies to this injury, illness or accident

| | |
|--|--|
| GENERAL SYMPTOMS A) Nervousness B) Irritability C) Fatigue D) Depression E) Loss Of Sleep F) Tension G) PMS H) Jaw Pain | MID BACK A) Pain 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe Pain Type 1) Sharp/Stabbing 2) Dull Ache B) Muscle Spasms In 1) Left 2) Right 3) Both |
| HEAD A) Headaches 1) Mild 2) Moderate 3) Severe How often (1 2 3 4 5 6) Per (Day / Week / Month) Are they 1) Sharp 2) Dull Are they 1) Constant 2) Intermittent Located 1) Back Of Head 2) Forehead 3) Temple 4) Right Side 5) Left Side 6) Behind Eyes B) Light Headed C) Memory Loss D) Fainting E) Blurred Vision F) Double Vision G) Sensitive To Light H) Loss Of Balance I) Hearing Loss J) Ringing In Ears | CHEST A) Deep Chest Pain 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe B) Pain Around Ribs 1) Left 2) Right 3) Both C) Shortness Of Breath D) Irregular Heartbeat |
| NECK A) Pain 1) Left 2) Right 3) Both Pain level 1) Mild 2) Moderate 3) Severe Pain Increased by: 1) Forward Movement 2) Backward Movement 3) Rotate Head Left 4) Rotate Head Right 5) Bend Neck Left 6) Bend Neck Right B) Stiffness C) Muscle Spasms D) Grinding / Grinding | ABDOMINAL SYMPTOMS A) Pain 1) Left 2) Right 3) Both B) Nervous Stomach C) Nausea D) Gas E) Constipated F) Djarreha G) Heartburn H) Indigestion I) Loss Of Appetite |
| SHOULDERS A) Pain In Joint 1) Left 2) Right 3) Both B) Pain Across Shoulders 1) Left 2) Right 3) Both C) Limitation Of Movement 1) Left 2) Right 3) Both D) Tension 1) Left 2) Right 3) Both | LOW BACK A) Upper Lumbar Pain 1) Left 2) Right 3) Both B) Lower Lumbar Pain 1) Left 2) Right 3) Both C) Sacro-Iliac Pain 1) Left 2) Right 3) Both D) Muscle Spasms 1) Left 2) Right 3) Both Low Back Pain Level 1) Mild 2) Moderate 3) Severe |
| ARMS A) Pain In Upper Arm 1) Left 2) Right 3) Both B) Pain In Elbow 1) Left 2) Right 3) Both C) Pain In Forearm 1) Left 2) Right 3) Both D) Pins & Needles (arms) 1) Left 2) Right 3) Both E) Pins & Needles (forearm) 1) Left 2) Right 3) Both F) Numbness In Arm 1) Left 2) Right 3) Both G) Numbness In Forearm 1) Left 2) Right 3) Both | HIPS AND LEGS A) Pain In Buttocks 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe B) Pain In Hip Joint 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe C) Pain Down Leg 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side Pain Radiates to 1) Knee 2) Calf 3) Foot D) Numbness Down Leg 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side E) Pins & Needles (legs) 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side F) Knee Pain 1) Left 2) Right 3) Both G) Leg Cramps 1) Left 2) Right 3) Both |
| HANDS A) Pain In Wrist 1) Left 2) Right 3) Both B) Pain In Hand 1) Left 2) Right 3) Both C) Pins & Needles (hand) 1) Left 2) Right 3) Both D) Numbness 1) Left 2) Right 3) Both | FEET A) Ankle Pain 1) Left 2) Right 3) Both B) Swollen Ankle 1) Left 2) Right 3) Both C) Foot Pain 1) Left 2) Right 3) Both D) Numbness of Heel 1) Left 2) Right 3) Both E) Swollen Feet 1) Left 2) Right 3) Both F) Cramps 1) Left 2) Right 3) Both |

Name _____

1) Date of Accident ____ / ____ / ____ 2) Time of Accident ____ : ____ (AM / PM)

3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian

4) Were you wearing seatbelts? (Y/N)

5) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6) How accident occurred: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

7) Where was your vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lt. Rear

8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lt. Side E) Rt. Front F) Lt. Front G) Rt. Rear H) Lt. Rear

9) Your approximate speed ____ MPH 10) Other vehicle approximate speed ____ MPH

11) What occurred at the moment of impact? (Circle as many as apply)

- A) Torso/body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat
- E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

12) Did you strike your: (Circle as many as apply)

- A) Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- B) Shoulder (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- C) Arm (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- D) Elbow (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- E) Wrist (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- F) Hip (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- G) Knee (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object
- H) Ankle (Lt/Rt) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lt. Door 6) Seat Frame 7) Unknown Object

13) Were you rendered unconscious? (Y/N) 14) Did you receive medical attention at the scene of the accident? (Y/N)

15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities

16) Were you: (Circle as many as apply) A) Shaken B) Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe: _____

In your own words, please describe accident: _____

How did you feel immediately after the accident? _____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

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

2557A Pacific Coast Highway Torrance, CA 90505

Ph: 310-626-8037 • Fax: 310-626-8038

Medical Authorization and Doctor's Lien

To: Attorney

From:

2557-A Pacific Coast Highway
Torrance, CA 90505
Phone (310) 626-8037
Fax (310) 626-8038

Re: _____

Date of Accident: _____

I do hereby authorize _____, to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing to him for services rendered to me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. Further, I hereby give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been examined and/or treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him or her.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may or may not recover said fee.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interests, the doctor will not await payment, but will require me to make payments on a current and timely basis.

Patient's Signature

Date

Please acknowledge this document by signing below and returning the original to the doctor's office in the enclosed self-addressed envelope. It is accepted by all concerned that a photocopy of this document shall be deemed as valid as the original.

The undersigned, being attorney of record for the above referenced patient, does hereby agree to observe all the terms of this document and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor.

Attorney's Signature

Date



Personal Injury Payment Policy

I hereby acknowledge that I am receiving (or about to receive) health care services from _____. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to make other provisions for the protection of the interest of the doctor; or
2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;

then I agree to pay for services rendered on a current basis. My bill will be paid in full as soon as my liability claim is settled or within three months of the date of my last treatment, whichever occurs first.

Patient's Signature

Date



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