

MIDWAY POINTE CHIROPRACTIC, INC

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PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

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INSURANCE INFORMATION

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

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PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

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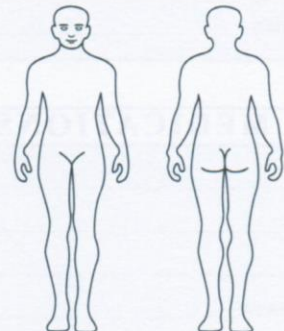
ACCIDENT INFORMATION

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) _____

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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



MIDWAY POINTE CHIROPRACTIC, INC.

Dr. Dan Schaffer
154 Midway Boulevard
Elyria, Ohio 44035
Phone: (440) 324-2040
Fax: (440) 324-2076

Privacy Notice

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

Midway Pointe Chiropractic, Inc. (MPC) is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this clinic to provide you with quality health care. This Privacy Notice details how your PHI may be used and disclosed to third parties and also details your rights regarding your PHI.

Disclosure for Treatment, Payment, and Operations Purposes

MPC may use and/or disclose your PHI for the purposes of:

- (a) *Treatment* – In order to provide you with the health care you require, MPC will provide your PHI to those health care professionals, whether on MPC's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, another physician treating you for lower back pain may need to know the results of your latest physician examination by this office.
- (b) *Payment* – In order to get paid for services provided to you, MPC will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, MPC may need to provide the Medicare program with information about health care services that you received in this clinic so that we can be properly reimbursed. MPC may also need to tell your insurance plan about treatment you will receive so that it can determine whether or not it will cover the treatment expense.
- (c) *Health Care Operations* – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for MPC to continue to provide quality and efficient care, it may be necessary for us to compile, use, and/or disclose your PHI. For example, MPC may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

NO CONSENT REQUIRED

MPC may use and/or disclose your PHI without a written Consent from you in the following instances:

- (a) *De-identified Information* – Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) *Business Associate* – To a business associate if MPC obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists us in undertaking some essential function, such as a collection agency or billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- (c) *Personal Representative* – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- (d) *Emergency Situations* –
 - (i) for the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your Consent as soon as possible; or
 - (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) *Communication Barriers* – If, due to substantial communication barriers or inability to communicate, we have been unable to obtain your Consent and we determine, in the exercise of our professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) *Public Health Activities* – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.
- (g) *Abuse, Neglect or Domestic Violence* – To a government authority if MPC is required by law to make such disclosure. If MPC is authorized by law to make such a disclosure, it will do so if we believe that the disclosure is necessary to prevent serious harm.

(h) *Health Oversight Activities* - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) *Judicial and Administrative Proceeding* - For example, MPC may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) *Law Enforcement Purposes* - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, we may disclose your PHI if we believe that your death was the result of criminal conduct.

(k) *Coroner or Medical Examiner* - MPC may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) *Research* - If MPC is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(m) *Avert a Threat to Health or Safety* - MPC may disclose your PHI we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) *Specialized Government Functions* - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(o) *Workers' Compensation* - If you are involved in a Workers' Compensation claim, MPC may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) *National Security and Intelligence Activities* - MPC may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(q) *Military and Veterans* - If you are a member of the armed forces, MPC may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDERS

MPC may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. MPC may call you by telephone as an appointment reminder, or leave a message on your answering machine or with the individual answering the phone. MPC may also send you birthday cards or information pertinent to your condition, new research, or treatment options to the address provided by you for that purpose.

DIRECTORY/SIGN-IN LOG

MPC maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within MPC's clinic suite. This information may be seen by, and is accessible to, others who are seeking care or services in MPC.

FAMILY/FRIENDS

MPC may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. We may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) *If you are present at or prior to the use or disclosure of your PHI, we may use or disclose your PHI if you agree, or if we can reasonably infer from the circumstances, based on the exercise of professional judgment, that you do not object to the use or disclosure.*

(b) *If you are not present, we 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 with your care.*

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS You have the right to:

- (a) *Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to Jodi Schaffer (Privacy Officer for MPC) or to any of MPC's staff members, or*
- (b) *Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, MPC is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to any MPC staff member. In your written request, you must inform MPC of what information you want to limit, whether you want to limit MPC's use or disclosure, or both, and to whom you want the limits to apply. If MPC agrees to your request, We will comply with your request unless the information is needed in order to provide you with emergency treatment.*
- (c) *Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to Jodi Schaffer, or any of MPC's staff members. MPC will accommodate all reasonable requests.*
- (d) *Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to Jodi Schaffer or any of MPC's staff members. MPC can charge you a fee for the cost of copying, mailing or other supplies.*

associated with your request. In certain situations that are defined by law, MPC may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to Jodi Schaffer. You must provide a reason that supports your request. MPC may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by MPC (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by MPC, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with MPC's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Jodi Schaffer or any MPC staff member. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but MPC may charge you for the cost of providing additional lists. MPC will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from MPC upon request to Jodi Schaffer or any MPC staff member.

(h) Complain to Dr. Schaffer or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with MPC, you must contact the privacy officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact Jodi Schaffer at (440) 324-2040, or via email at ElyriaChiro1@aol.com.

MPC'S REQUIREMENTS

MPC:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing our legal duties and privacy practices with respect to your PHI.

- (b) Is required to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law where state and federal laws conflict, and where state law is more stringent in the area of privacy.

- (c) Is required to abide by the terms of this Privacy Notice.

- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

- (e) Will distribute any revised Privacy Notice to you prior to implementation.

- (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE This Notice is in effect as of ___/___/___.

I have read and understand my rights under the new HIPAA privacy law. The original document will be kept on file in my patient records and I have the right to request a copy of this notice at any time.

Patient Signature: _____

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PERSONAL INJURY HISTORY

Patient's Name: _____ Today's Date: _____
Date of Accident: _____

1. Where were you seated in the vehicle?
2. Were you wearing a seatbelt?
If yes, was it a lapbelt or shoulder harness?
3. Was the vehicle stopped or moving at the time of impact?
If it was moving, how fast was it moving?
4. Describe the accident:

5. What body parts struck which parts of the vehicle?
6. Did you lose consciousness? If yes, how long?
7. Did you receive any cuts or bruises?
8. Did the police arrive at the scene? Was either driver issued a citation?
9. Were you taken to the hospital? If yes, which one?
10. What x-rays and/or treatments were performed?
Discharge recommendations: cervical brace/sling/medication
see family doctor/see Dr. _____
11. What treatments have you had since that time?
12. What are your present complaints?
13. What is the history of those complaints?
14. Do you have any previous automobile or work related accidents?
15. What is your occupation? Have you lost time from work?
16. Do you have legal representation? If yes, who?
17. What is the estimated damage to the vehicle?