Patient’s Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information and to hold violators accountable, with appropriate penalties for violation of a patient’s right to privacy.

AS A PATIENT OF THIS PRACTICE
1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice’s facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be $25 per page.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor’s refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient’s disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.

PATIENTS STATEMENT OF PRIVACY RIGHTS
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such service, shall be part of a “chain of trust” under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
11. You are entitled to this practice’s best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Dept. of Health and Human Ser., Office of Civil Rights, which Administers HIPAA, with questions or to file a complaint at, Toll Free: 1-877-696-6775 or Email: OCRComplaint@hhs.gov or visit their web site at www.hhs.gov/ocr
Patient’s Affirmation of Receipt
Of Patient’s Statement of Privacy Rights

I hereby acknowledge receipt of this office’s Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information as a patient of this practice.

Affirmed,

_____________________________________________________
Patient Name

____________________
Date
MUNGOVAN CHIROPRACTIC

FINANCIAL POLICY

I understand that the physician’s billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the physician because of:

- co-insurance or co-pay amounts
- yearly deductible amounts
- non covered services
- out of network charges
- terminated coverage
- exhausted automatic benefits
- denied workers compensation claim
- no insurance coverage
- no referral obtained from primary physician
- failure to respond to insurance carrier correspondence
- failure to respond to coordination of benefits inquiry

I understand that I will receive a statement for any balance due, after the claim has been processed by my carrier. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days. Any balances not paid within the agreed terms are subject to a service charge of 1 ½% per month.

If I am unable to pay the entire amount, I am responsible to immediately, on receipt of statement, to call this office @ 260-447-1067.

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in Collection Agency action.

Signature: ______________________________ Date __________
Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment.

Chiropractic adjustments are the moving of bones with the doctor’s hands or with the use of a machine. Frequently adjustments create a “pop” or “click” sound / sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, ect. On occasion when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most common serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the “extension-rotation-thrust atlas adjustment”. We do not do this type of adjustments on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies show (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniated: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft tissue injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement.Rarely a chiropractor adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such
things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone’s skin has a different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease of condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

___________________  ______________________________
Patient Name Printed                                                   Today’s Date

___________________________
____________________________________
Patient Signature  Parent or Guardian Signature for Minor
CONFIDENTIAL PATIENT INFORMATION    DATE________________

Name________________________________________   Home Phone ______________________
Address_______________________________ City___________________ St_____ Zip________
S.S. #_____________________ Age_______ Birth Date_______________  Marital:  M  S  W  D
Occupation____________________________ Employer_________________________________
Address__________________________________________ Work Phone____________________
Spouse Name or Nearest Relative ______________________________Phone #_______________
REFERRED BY: ________________________________________________________________

SYMPTOMS:
Reason for this appointment________________________________________________________
Other doctor seen for this condition?_________________________________________________
Is this condition related to employment? ________________________________
Is this condition related to accident (auto or other) ______________________________________
Number of days lost from work __________ Date symptoms appeared ______________________
Have you ever had same or similar condition?  No___ / Y  es____  When & Describe___________

What operations have you had?___________________________ When_____________________

Serious Illness________________________________________ When_____________________
What medication or drugs are you taking?_____________________________________________

Have you suffered from:   (Please circle any that apply)

Heart Trouble        Cancer           Diabetes          Arthritis       Dizziness       Headaches       Backaches       Numbness
Nervousness           Asthma           Hernia           Neuritis        Sinus Trouble   Anemia           Digestive Disorder
Rheumatic Fever       Osteoporosis    Thyroid Problems  Appendicitis  Prostate Problems Glaucoma
Mononucleosis         Cataracts        Depression       Pacemaker       Stroke          Pinched Nerve Ulers
High Cholesterol      Emphysema       Parkinson’s Disease     Gout       Migraine Headache Goiter
Scarlet Fever         Typhoid Fever Multiple Sclerosis Bronchitis Epilepsy Polio Tonsillitis
Prosthesis            Chicken Pox     Aids/HIV          Alcoholism     Breast Lump Mumps Whooping
Cough                 Herpes           Hepatitis         Tuberculosis Pneumonia Kidney Disease Miscarriage
Bulimia               Herniated Disc Anorexia        Tumors        Liver Disease Fractures Bleeding Disorder
Venereal Disease      Rheumatoid Arthritis

* WOMEN *   Are You Pregnant?  Y / N  Nursing?  Y / N  Birth Control Pills Y / N

I understand and agree that health and accident insurance policies are an arrangement between
my insurance company and myself – not between  my insurance company and this office. I authorize
Mungovan Chiropractic to release any medical information and to complete any usual and customary
reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are
rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also
understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any
fees for professional services will be immediately due and payable.

Patient’s Signature___________________________________________Date________________

E-mail____________________________________________________
**Oswestry-Type Pain-Disability Questionnaire**

This questionnaire has been designed to give the examiner information about pain and how it affects your ability to manage in everyday life. Please circle, in each section, only one statement that most applies to you.

**Section 1: Pain intensity**
1. I can tolerate the pain I have without having to use painkillers.
2. The pain is bad, but I manage without taking painkillers.
3. Painkillers give complete relief from pain.
4. Painkillers give moderate relief from pain.
5. Painkillers give very little relief from pain.
6. Painkillers have no affect on the pain, and I do not use them.

**Section 2: Personal care (washing, dressing, etc.)**
1. I can look after myself normally, without causing extra pain.
2. I can look after myself normally, but it causes pain.
3. It is painful to look after myself, and I am slow and careful.
4. I need some help, but 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.

**Section 3: Lifting**
1. I can lift heavy weights without increased pain.
2. I can lift heavy weights, but it gives added pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, such as 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 lift only very light weights.
6. I cannot lift or carry anything at all.

**Section 4: Walking**
1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than 1 mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk using a cane or crutches.
6. I am in bed most of the time and have to crawl to the toilet.

**Section 5: Sitting**
1. I can sit in any chair as long as I like.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than an hour.
4. Pain prevents me from sitting more than ½ hour.
5. Pain prevents me from sitting more than 10 minutes.
6. Pain prevents me from sitting at all.
Section 6: Standing
1. I can stand as long as I want without added pain.
2. I can stand as long as I want, but it gives me added pain.
3. Pain prevents me from standing for more than 1 hour.
4. Pain prevents me from standing for more than 30 minutes.
5. Pain prevents me from standing for more than 10 minutes.
6. Pain prevents me from standing at all.

Section 7: Sleeping
1. Pain does not prevent me from sleeping well.
2. I can sleep well only by using sleeping tablets.
3. Even when I take sleeping tablets, I have less than 6 hours of sleep.
4. Even when I take sleeping tablets, I have less than 4 hours of sleep.
5. Even when I take sleeping tablets, I have less than 2 hours of sleep.
6. Pain prevents me from sleeping at all.

Section 8: Sexual activity
1. My sexual activity is normal and causes no extra pain.
2. My sexual activity is normal but causes some pain.
3. My sexual activity is nearly normal but is very painful.
4. My sexual activity is severely restricted by pain.
5. My sexual activity is nearly absent because of pain.
6. Pain prevents any sexual activity at all.

Section 9: Social Life
1. My social life is normal and gives me no extra pain.
2. My social life is normal but increases the degree of pain.
3. Pain has no significant effect on my social life, other than limiting my more energetic interests, such as dancing.
4. Pain restricts my social life, and I do not go out often.
5. Pain has restricted my social life to my home.
6. I have no social life because of pain.

Section 10: Traveling
1. I can travel anywhere without added pain.
2. I can travel anywhere, but it gives me added pain.
3. Pain is bad, but I manage journeys of more than 2 hours.
4. Pain restricts me to a journey of less than 1 hour.
5. Pain restricts me to short, necessary journeys that take no longer than 30 minutes.
6. Pain prevents me from traveling, except to the doctor or hospital.