

We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

11. **Military and Veterans.** If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.
12. **National Security and Intelligence Activities.** We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities.
13. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; or (iii) for the safety and security of the correctional institution.

E. USE AND DISCLOSURE PURSUANT TO YOUR WRITTEN AUTHORIZATION.

Except for the purposes identified above in Sections B through D, we will not use or disclose your health information unless we have your specific written authorization. You have the right to revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the original authorization.

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from Laurie Douglass, our HIPAA Privacy Officer. She can also tell you if there are cost(s) associated with providing you with the requested information.

1. **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about your care. If we deny your request, you may request that the denial be reviewed.
2. **Right to Amend.** You have the right to request an amendment to your health information that we maintain. We may deny your request if it is not properly made or if the information: (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment); (b) is not part of the information that we keep; (c) is not part of the information which you are permitted to inspect and copy; or (d) is not accurate and complete.

You have the right to an accounting of disclosures we make, but this accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations, or as a result of a written authorization that you have signed.

4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, our agreement must be in writing and signed by you and us.
5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
6. **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

G. QUESTIONS OR COMPLAINTS.

If you have any questions regarding this Notice or want more information about our privacy practices, please contact Laurie Douglass. If you believe your privacy rights have been violated, you may file a complaint with us, or with the Secretary of the Department of Health and Human Services (HHS). Our address is 11462 Business Blvd., Eagle River, AK 99577-0849. All complaints must be submitted in writing. You will not be penalized for filing a complaint.



Chugach Chiropractic Clinic LLC

HIPAA

Notice of

Privacy Practices

Myron G. Schweigert, D.C.
11462 Business Blvd.
Eagle River, AK 99577
Phone: 907-694-9224
Fax: 907-694-1066
www.careforyourspine.com

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.

A. PURPOSE OF THE NOTICE

Chugach Chiropractic Clinic LLC has always been committed to protecting your privacy, but state and federal laws and regulations require us to formally adopt policies and notify you of them. Our policies cover all of your health information that we create or maintain, and any information we receive from other health care providers or facilities.

We will abide by the policies described in this Notice, but we may make changes as required by law. If we do make changes, those changes will apply to all information presently in our possession, and any that we may create or receive in the future. We will post a copy of the current Notice in our patient waiting area. These policies and this Notice cover any health care professional authorized to enter information into your medical record maintained at our clinic, including all employees, students, residents, and other service providers who have access to your health information at our office.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

1. **Treatment, Payment and Health Care Operations.** We will only disclose your health information for treatment, payment, and health care operations purposes. The following are examples:
 - a. **Treatment.** To provide you with health care. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other people involved in your health care. For example, if you need physical therapy services, we will talk with the physical therapist to coordinate services, or, if we were to refer you to another health care provider, we would share information to coordinate your care.
 - b. **Payment.** We will use or disclose your health information to bill and receive payment from you, an insurance company, or another third party. We may disclose health information to your health plan to obtain prior approval for services or coverage, including referring you to a specialist, or to perform a diagnostic test.
 - c. **Health Care Operations.** We will use or disclose your health information for administrative, educational, quality assurance

or business practice purposes. For example, we may use your health information to evaluate our staff's level of care, or to evaluate whether certain treatment is effective. We may disclose your health information to physicians, nurses, technicians, or health profession students for educational purposes.

C. USE AND DISCLOSURE OF HEALTH INFORMATION IN SPECIAL SITUATIONS

We may use or disclose your health information in certain special situations, including those described in Section D of this Notice.

1. **Appointment Reminders.** To remind you of an appointment with us.
2. **Treatment Alternatives and Health-Related Products and Services.** To inform you of treatment, products or services of interest to you. For example, if you are diagnosed with a diabetic condition, we may inform you of diabetic instruction classes.
3. **Facility Directory.** We may use or disclose certain limited health information about you to a facility (like a Hospital) that maintains a directory of patients. This information may include your name, your religious affiliation, and a general description of your condition.
4. **Family Members and Friends.** We may disclose certain health information about you to family members and friends involved in or paying for your care when: (a) we have your verbal consent, (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object. For example, if your spouse accompanies you into the exam room, we will assume you agree to disclosure while your spouse is present.

We also may disclose information to family members or friends when you are unable to agree or object to such disclosure, but only if, in our professional medical judgment, the disclosure is in your best interest with regard to your care. For example, if you are in recovery from anesthesia, we may share information with the person who accompanied you to surgery; or we may share information with a family member or friend who calls us to request a prescription refill for you.

D. OTHER PERMITTED OR REQUIRED USE AND DISCLOSURE OF HEALTH INFORMATION.

We may be required or permitted by law to use or disclose your health information without your permission. Examples include:

1. **As Required by Federal, State, or Local Law.** The Federal Department of Health and Human Services (HHS) can require us to disclose your information to determine whether we are adequately protecting your privacy!

2. **Public Health Activities.** We are required to disclose private health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; to report births, deaths, suspected abuse or neglect; reactions to medications, or to facilitate product recalls.
3. **Health Oversight Activities.** We may be required to disclose your health information to a health oversight agency for oversight activities, including audits, investigations, inspections, or licensure and certification surveys.
4. **Judicial or Administrative Proceedings.** We may disclose your health information to courts or administrative agencies that hear and resolve lawsuits or disputes. These disclosures may follow a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but in those instances we will make efforts to (i) notify you of the request for disclosure or (ii) try to obtain an order protecting your health information.
5. **Worker's Compensation.** We may be required to disclose your health information to a worker's compensation program if your health condition may arise from a work-related illness or injury.
6. **Law Enforcement Official.** We may be required to disclose your health information in response to a request by a law enforcement official; to report criminal activity; or to respond to a subpoena, court order, warrant, summons, or similar process.
7. **Coroners, Medical Examiners, or Funeral Directors.** We must disclose some of your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may be required to disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.
8. **Organ Procurement Organizations or Tissue Banks.** If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplant, or tissue banking for the purpose of facilitating organ or tissue donation or transplant.
9. **Research.** We may use or disclose your health information for research purposes under certain limited circumstances. All research projects are subject to a special approval process, and we will not disclose your information until this special approval process has been completed. We may use or disclose your health information to individuals preparing to conduct the research project but only to assist them in identifying patients who may qualify to participate in the project. Those disclosures will only be made onsite at our facility and we will first ask your specific permission before the researcher has access to your name, address or other identifying information.



Chugach Chiropractic Clinic LLC

Patient Information

Todays Date: _____ / ____ / ____ Date of Injury: ____ / ____ / ____ Social Security #: _____

Patient Name: _____ Employer: _____
Last, First, MI

Mailing Address: _____ Occupation: _____

City, State, Zip _____ Emergency Contact: _____

Physical Address: _____ Emergency Phone #: _____
(if different from Mailing)

City, State, Zip _____

Birthdate: _____ / ____ / ____

Home Phone: _____ (____) - _____

Work Phone: _____ (____) - _____ Marital Status: M S W D Work Related Injury? Y N

Cell Phone: _____ (____) - _____ Sex: M F Automobile Accident? Y N

Person responsible for bill: _____

Social Security Number: _____

Phone #: _____ Date of Birth: _____

Insurance Information: *(Please let us copy your Insurance Card)*

Primary Ins Co: _____ Secondary Ins Co: _____

Ins. Co. Phone #: _____ Ins. Co. Phone #: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Group No.: _____ Group No.: _____

Policy ID No.: _____ Policy ID No.: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holder's Birth Date: _____ / ____ / ____ Policy Holder's Birth Date: _____ / ____ / ____

Assignment & Release - By signing below, I authorize Chugach Chiropractic Clinic LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chugach Chiropractic Clinic LLC. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any reasonable collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

Consent to Treatment - By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signature: _____ **Date:** _____

For Office Use Only

Effective Date: _____ Benefit Year: _____ Insurance Adress: _____

Deductible: _____ Amount Met: _____

Percentage covered: _____ % up to: \$ _____ OOP Then: _____ % OOP Met: _____

Chiro Coverage: Yearly Max: _____ or _____ visits per/yr. Copay: _____

Limitations: _____

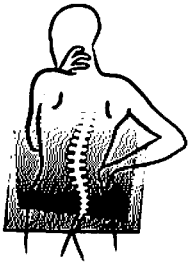
X-ray Coverage: _____ Massage: _____

Are modalities covered as chiro or PT? _____

P.T.: _____

Are supplies (vitamins, splints, etc.)covered? _____ Orthotic Coverage: _____

Spoke to: _____ Verified By: _____ Date: _____



Chugach Chiropractic Clinic LLC

P.O. Box 770849, Eagle River, AK 99577-0849

Phone (907) 694-9224 Fax (907) 694-1066

www.careforyourspine.com

Financial Policy

It is the policy of Chugach Chiropractic Clinic LLC to assess a \$25 missed visit fee to patients who cancel appointments with less than 24 hours notice or patients who miss their appointments without notifying our office. One missed visit will be considered "grace"; however, all missed visits thereafter will be assessed the missed visit fee. Please understand that we attempt to serve as many patients as possible, and when a visit is missed, it represents time that could have been used to provide care for others.

In order to help our patients determine their responsibility toward payment for services, please read the following, and initial your preference for payment of your account:

Private Pay: (please initial)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C _____ Your health insurance policy most likely has a deductible amount as well as a percentage of your fees for which you, as the patient, are responsible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of the charges incurred. It is our policy to have the initial visit fees paid by the patient at the time of his/her appointment.

Our business office will contact your insurance company and inform you of your coverage for chiropractic care. We will then determine your eligibility.

Statements are sent out to a patient's insurance company on a regular basis. Your insurance company will inform you of benefits received and paid. Our office will notify you if there are any amounts unpaid or if there is a credit balance. We request that you clear up any and all balances that are due at that time.

If there is an overpayment at the time you have finished your series of treatments, the credit balance will be refunded. If any outstanding balances exist on any adjoining family accounts, your credit balance will be applied to that account or, if you wish, applied toward further care.

Supplies must be paid for when they are received.

Health policies are an arrangement between an insurance company and you, the insured. We will be happy to cooperate with you in the preparation of your insurance forms. Any amount paid directly to our office will be promptly credited to your account. If the insurance company should send you the check, please bring the check to our office.

IT IS IMPORTANT FOR YOU TO UNDERSTAND, HOWEVER, THAT ALL HEALTH SERVICES RENDERED TO YOU ARE CHARGED TO YOU AND ARE YOUR PERSONAL RESPONSIBILITY.

IF YOU HAVE ANY QUESTIONS, PLEASE LET US KNOW. WE WANT YOU TO HAVE A CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY SO THAT TOGETHER WE CAN CONCENTRATE ON RETURNING YOU TO GOOD HEALTH.

Patient/Responsible Party Signature _____ Date _____



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Receipt of Notice of Privacy Practices

I have had an opportunity to review the Notice of Privacy Practices.

Patient's Printed Name

Date of Birth

Patient's Signature or that of Legal Representative

Today's Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Individual



Chugach Chiropractic Clinic LLC

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Symptom Questionnaire

Patient Name: _____

Date: _____

Reason for today's visit: New Injury Old Injury Chronic Pain Wellness Visit

Are you in pain? Yes No

Rate your pain with the following scale. No Discomfort 1 2 3 4 5 6 7 8 9 10 Intense Pain

When did your condition begin or accident occur? _____ Where did your injury/accident occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Work Sleep Daily Routine If so, how? _____

Has this or something similar happened in the past?

Yes No Explain: _____

Please use the body chart below to mark affected areas.

Have you been treated by a physician for this pain?

Yes No If so, where? _____

Have you ever been treated by a chiropractor?

Yes No If so, who? _____

Are you taking any of the following medications? What types?

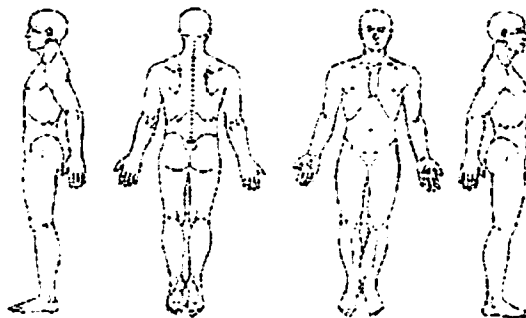
Pain Killers _____

Muscle Relaxants _____

Insulin _____

Supplements _____

Other _____



Left

Back

Front

Right

Do you have or have you had any of the following medical conditions or procedures?

Heart Attack / Stroke

Ulcers / Colitis

Fainting / Seizures / Epilepsy

Heart Condition / Pacemaker

Cancer / Chemotherapy

Severe / Frequent Headaches

Artificial Valves

Anemia / Diabetes

Sinus Problems

Artificial Bones / Joint / Implants

Kidney Problems

Emphysema / Asthma

Arthritis

Frequent Neck Pain

Tuberculosis

High / Low Blood Pressure

Lower Back Problems

Difficulty Breathing

Please list any surgeries with dates and / or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything you are allergic to:

Family History (list any major diseases such as cancer, diabetes, heart problems, bone / joint diseases):

Do you exercise? No Yes _____ amounts per week Are you dieting? No Yes Since: _____

Do you smoke? No Yes If yes, how much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch Supports

For Women: Are you pregnant? Yes No If so, how many weeks? _____