individual with an accounting of such disclosures it made and all of its business associates disclosures; or (2) provide an individual with an accounting of the disclosures made by Algonquin Chiropractic Center and a list of business associates, including their contact information, who will be responsible for providing an accounting of such disclosures upon request.

***Request Confidential Communications***

You have the right to request how we communicate with you to preserve your privacy. We will accommodate all reasonable requests.

***File a Complaint***

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our facility or directly to the Secretary of the United States Department of Health and Human Services:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201.
Phone: (202) 619-0257
Toll Free: (877) 696-6775.

To file a complaint with our facility, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer.

***A Paper Copy of This Notice***

You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

***Our Responsibilities***

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization, except as described in this notice.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Contact or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. You may contact our Privacy Contact, Karey Richards at (847) 854-2000 for further information about the complaint process.

This notice was published and becomes effective on January 8, 2015

**Algonquin Chiropractic Center**
**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. If you have any questions about this notice please contact our Privacy Contact who is Karey Richards.**

We are required by law to provide you with this notice explaining our privacy practices with regard to your medical information and how we may use and disclose your protected health information (PHI) for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

Protected Health Information (PHI) consists of individually identifiable health information, which may include demographic information our company collects from you or creates or receives by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

This Notice of Privacy Practices became effective on April 14, 2003 and was amended on January 8, 2015.

***Understanding Your Health Record/Information***

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- source of data for medical research

• source of information for public health officials charged with improving the health of the nation
• source of data for facility planning and marketing
• a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve Understanding what is in your record and how your health information is used helps you to:
• ensure its accuracy
• better understand who, what, when, where, and why others may access your health information
• make more informed decisions when authorizing disclosure to others

***How this Office May Use or Disclose Your Health Information***

This company collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

***Treatment.*** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We may provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

***Payment.*** We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

***Health Care Operations***. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as software support, billing, and collections companies. We have a written contract with each of our business associates that contains terms requiring the business associates and any subcontractors they may hire to protect the confidentiality of your medical information.

***Other Ways We May Use and Disclose Your Protected Health Information Appointment Reminders***. We may use and disclose medical information to contact and remind you about appointments. Should we call and you not be at home, we may leave minimally necessary information to accomplish our purposes with a family member, significant other, or in an e-mail, voice mail, texting device, or answering machine.

***Sign in sheet.*** We may have you sign in when you arrive at our office and we will call out your name when we are ready to see you.

***Notification and communication with family.*** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may disclose your health information to any person(s) that accompanies you at the time of your appointment and is present while our staff member is treating you and/or discussing your care with you. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care.

***Future communications***. We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

***Required by law***. As required by law, we may use and disclose your health information, to the following types of entities including but not limited to:

- Public health authorities for purposes related to: preventing or controlling disease, injury or disability;
- Authority that receives reports on abuse or neglect or reporting domestic violence;
- Food and Drug Administration
- Health oversight activities-we may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and state law. • Law enforcement/legal proceedings-we may disclose health information for law enforcement purposes as required by law or in response to a subpoena
- Coroners
- Organ or tissue donation
- Public safety
- Specialized government functions such as: national security and intelligence agencies, Worker's compensation, Inmates, Research

***Change of Ownership***. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another provider.

***Breach Notification***. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification.

***Uses or Disclosures Not Covered by this Notice***

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

***Accounting of E-Health Records for Treatment, Payment, and Health***

Algonquin Chiropractic Center does not currently have to provide an accounting of disclosures of PHI to carry out treatment, payment, and health care operations. However, starting January 1, 2014, the HITECH Act will require Algonquin Chiropractic Center to provide an accounting of disclosures through an e-health record to carry out treatment, payment, and health care operations. This new accounting requirement is limited to disclosures within the three-year period prior to the individual's request. Algonquin Chiropractic Center must either: (1) provide an individual with an accounting of such disclosures it made and all of its business associates disclosures; or (2) provide an individual with an accounting of the disclosures made by Algonquin Chiropractic Center and a list of business associates, including their contact information, who will be responsible for providing an accounting of such disclosures upon request.

***Patient Rights Related to Protected Health Information***

Although your health record is the physical property of the facility that compiled it, the information belongs to you. You have the right to:

***Request an Amendment***

You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer.

***Request Restrictions***

You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. Your request must be made in writing. If a patient pays in full for their services out of pocket they can request that the information regarding the service not be disclosed to the patient's third party payer since no claim is being made against the third party payer.

***Inspect and Copy***

You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. You have the right to access your own e-health record in an electronic format and to direct Algonquin Chiropractic Center to send the e-health record directly to a third party.

Starting January 1, 2014, Algonquin Chiropractic Center will provide an accounting of disclosures through an e-health record to carry out treatment, payment, and health care operations within the three-year period prior to the individual's request. Algonquin Chiropractic Center must either: (1) provide an

**Algonquin Chiropractic Center, P.C.**

2210 Huntington Dr. N Algonquin, IL 60102 847-854-2000

## Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Algonquin Chiropractic's Notice of Privacy Policies, dealing with how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:_____Witnessed by:_____

---

## Authorization to Release Information to Family Members

I authorize Algonquin Chiropractic to release my records and any information to the following individuals.

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature

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## PATIENT HEALTH HISTORY

Patient Name: _____

Address: _____

Email: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____

Name of Wife/Husband: _____ Cell Phone: _____

Is this condition due to injury or sickness arising out of patient's employment: YES or NO

Is this condition due to injury or sickness arising out a car accident: YES or NO

Name of Primary Care Physician: _____

Name of Specialist(s) that you see: _____

Referred to Algonquin Chiropractic by: _____

**PLEASE LIST CURRENT IF APPPLICABLE. IF MORE THAN 6, PROVIDE A WRITTEN LIST FOR THE DOCTOR:**

| MEDICATIONS | VITAMINS | ALLERGIES |
|---|---|---|
| 1)_____ | 1)_____ | 1)_____ |
| 2)_____ | 2)_____ | 2)_____ |
| 3)_____ | 3)_____ | 3)_____ |
| 4)_____ | 4)_____ | 4)_____ |
| 5)_____ | 5)_____ | 5)_____ |
| 6)_____ | 6)_____ | 6)_____ |

| SURGERIES | YEAR | IN PATIENT PROCEDURE? |
|---|---|---|
| 1)_____ | _____ | YES or NO |
| 2)_____ | _____ | YES or NO |
| 3)_____ | _____ | YES or NO |
| 4)_____ | _____ | YES or NO |
| 5)_____ | _____ | YES or NO |
| 6)_____ | _____ | YES or NO |

**SOCIAL HISTORY.** Please circle the one that applies per category: *(H) Heavy (M) Moderate (L) Light (N) None*

| | | | |
|---|---|---|---|
| Alcohol | H / M / L / N | Exercise | H / M / L / N |
| Coffee | H / M / L / N | Sleep | H / M / L / N |
| Tobacco | H / M / L / N | Drugs | H / M / L / N |

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**FAMILY HEALTH HISTORY**

**Mark ALL conditions that run in your family** **Relationship: (mother, father, sibling)**

- ○ Cancer _____
- ○ Cholesterol _____
- ○ Anemia _____
- ○ Diabetes _____
- ○ Heart Problems / Stroke _____
- ○ High Blood Pressure _____
- ○ Genetic Disorders _____
- ○ Other _____

**MUSCULOSKELETAL** (Circle all that apply)

| | | | |
|---|---|---|---|
| Fallen in last 6 months | Fall injuries | Easily broken bones | Back pain |
| Joint pain | Joint stiffness | Joint swelling | Muscle aches |
| Muscle weakness | Difficulty walking | | |

Other: _____

**NEUROLOGIC** (Circle all that apply)

| | | |
|---|---|---|
| Frequent headaches | Dizziness | Stroke or stroke symptoms |
| Difficulty speaking | Fainting/Blacking out | Paralysis Memory difficulties |
| Tremor Sleep difficulties | Feeling sad/lonely | Nervous/anxiety |
| Psychiatry treatment | Numbness/Unusual sensation in arms and legs | |
| Loss of interest in usual activities | Other: _____ | |

Please list below anything else that is of concern to you or that you feel we should know:

_____

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give the office power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.* ***I understand that PAYMENT IS DUE AT THE TIME OF SERVICE. In the event any unpaid balance is 30 days past due from the date of last service, that patient will be responsible for any and all reasonable collection fees, attorney fees, court costs and any collection agency fees related to the collection of the unpaid balance.***

Patient Signature _____ Date_____

Guardian/Authorizing Signature _____ Date_____

**Algonquin Chiropractic Center, P.C.**

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# Major Problem Index

Patient Name: _____ Date: _____

List Your ONE Major Problem: _____

Date of Recent Injury: _____

Have you had it before? When? _____

Have you had treatment in the past for it? List Doctors seen and procedures:

_____

_____

Was this due to trauma? Any past trauma? _____

How did this start, what was the cause?

_____

_____

My Pain Increases when I cough:
Yes_____ No_____

I have lost control of my bowel or bladder:
Yes_____ No_____

The Pain wakes me up at night:
Yes_____ No_____

I have pain or numbness in my:
Arms, Hands: Yes_____ No_____
Legs, Feet: Yes_____ No_____

I have weakness in my:
Arms, Hands: Yes_____ No_____
Legs, Feet: Yes_____ No_____

My pain is:
_____worse in the morning
_____worse as the day goes on
_____time of day does not matter

Pain (0-10): Average pain _____/10
Worst pain _____/10

Pain quality (circle all that apply):

| | |
|---|---|
| Achy | Numbness/Tingling |
| Sharp | Throbbing |
| Stiff | Burning |

Pain frequency: Circle one
Constant (76-100% of the time)
Frequent (51-75% of the time)
Occasional (25-50% of the time)
Infrequent (0-25% of the time)

Symptoms made worse by: _____

_____

Symptoms decreased by: _____

_____

* In the event xrays are performed & Sent to radiologist

REFERRING PHYSICIAN: **ALGONQUIN CHIROPRACTIC**

TYPE OF CASE: ____GRP. HEALTH ____MEDICARE ____WORK COMP ____PI ____PI WITH MEDPAY

____BILL PATIENT ____BILL DOCTOR Date Of Accident: _____
(Work Comp and PI)

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: ( ) _____ DOB: ____/____/____ SS# [redacted]

SEX: M OR F RELATION OF INSURED: SELF SPOUSE CHILD OTHER: _____

EMPLOYER: _____ TELEPHONE: _____

ADDRESS: _____

SEND BILLS TO: (*CIRCLE ONE*) ATTORNEY INSURANCE PARENT PATIENT GUARDIAN

NAME: _____

ADDRESS: _____

INSURANCE INFORMATION: PRIMARY SECONDARY

NAME: _____ _____

ADDRESS: _____ _____

CITY / STATE / ZIP: _____ _____

POLICY OR CLAIM NUMBER: _____ _____

GROUP: _____ _____

ADJUSTOR: _____ _____

INSURED IF DIFF. FROM PT: _____ _____

ADDRESS: _____ _____

INSURED SOC. SEC. #:(____) ____/____/____ (____) ____/____/____
BC/BS PREFIX BC/BS PREFIX

I, _____ consent to Specialized Radiology Consultants ("SRC") use and disclosure of my Protected Health Information for the purpose of providing radiology readings on me, for purposes relating to the payment of services rendered to me, and for SRC's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management, and other general operation activities. I understand that the SRC's diagnosis of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, **"Protected Health Information"** means any information, including my demographic information, created or received by SRC, that relates to my past, present, or future physical or mental health or condition: the provision of health care to me; or the past, present, or future payment for the provision of health care services to me: and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of SRC, but SRC is not required to agree to these restrictions. However, if SRC agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the SRC's Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I understand that if I desire a copy, I may call the above number and one will be copied and mailed to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or SRC has acted in reliance on this consent.

I understand that there will be a *separate bill* for SRC's radiology interpretation and written report. I also authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to SRC and accept responsibility for any remaining balance billed.

_____ DATE: _____
Signature of Patient or Personal Representative

SPECIALIZED RADIOLOGY CONSULTANTS
WHEATON, IL (630) 462-9772


# Algonquin Chiropractic Center, P.C.

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## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

*Please initial after reading each paragraph*

**Chiropractic Care:** I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Initial: _____

**X-Ray Verification:** I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Initial: _____
Date of last menstrual period. _____ N/A if Male _____

**Permission to Contact:** I grant permission to be called/texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. Initial: _____

**Payment Verification:** I acknowledge that any insurance I may have is an agreement between the carrier and me. I am responsible for the payment of any services I receive. Initial: _____

**General Verification:** To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Initial: _____

Signature _____ Date _____

---

***Complete if the patient is a minor**

Print child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature _____ Date _____

Witness Signature _____ Date _____