Notice of privacy practices

Your Information. Your Rights. Our Responsibilities. 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.
Your Rights

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission

- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Device Technology
We can share health information about you when we use our technology input devices for voice file transcription technologies and screen reading technologies on our smart phones, tablets and computers to document care and practice management.
Social Media and Community Success
We can share health information about you that you share with us including testimonials and pictures regarding your care and interactions with our clinic.
Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Patient information

Name:_____ **Todays Date:** ___/____/____

Date of Birth: ___/____/_____ **Gender:** F M Decline

Last 4 of your social: _____

Adress

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone (_____)_____

Would you like to **receive reminders via Text message**? Yes ( ) No ( )

Which number should we send it to? (___)_____, same as above ( )

E-Mail Adress: _____

Would you like to **receive reminders via E-Mail**? Yes ( ) No ( )

Is the Patient under 18 years of age or has an appointed legal Guardian?

Name of Parent/Guardian: _____

Phone (___)_____

Who should we contact in the event of an emergency?

Name: _____ **Relationship:** _____

Phone: (___)_____

Your Occupation: _____

Employer: _____

Student at: _____ FT ( ) PT ( )

Insurance Carrier: _____

Policy Holder: _____ **Date of Birth:** ___/___/____

ID Number: _____ **Group:** _____

Primary Health Care Provider: _____

Phone (___)_____

Permission to contact PCP if necessary? Yes ( ) No ( )

Women ONLY : Are you pregnant or is there any possibility you may be?

Pregnant? Yes ( ) No ( ) Due Date: ___/____/____

Patient Signature: _____

Parent/Guardian Signature: _____

Office Policy

1. Acknowledgment of receipt of notice of privacy practice and consent to treat

By my signature below, I hereby acknowledge that I have received a copy of the Clinic's NOTICE OF PRIVACY PRACTICES (attached below).

2. Consent to treatment

By my signature below, I do hereby voluntarily consent to treatment by the provider(s) of the clinic for an examination and to any related diagnostic procedures and treatments as necessary in the judgment of the provider(s). I acknowledge that the practice of medicine is not an exact science. I acknowledge that no guarantees have been or can be made to me as a result of such procedures and treatments.

3. Consent to disclose my general health information

By my signature below, I hereby authorize the clinic to disclose my medical information so that the clinic may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the clinic (e.g., quality assurance). I also authorize the clinic to disclose my medical information to insurers and providers outside of the clinic when necessary for purposes of my treatment, payment for that treatment, and for their health care operations. By my signature below, I also authorize the clinic to communicate with me by phone (using the numbers listed above) and to disclose my general health information on my home answering machine/voicemail, on my cell phone voice mail, and to my spouse, children, and the following additional family and friends.
Names of individuals the clinic is authorized to communicate with:

_____

_____

4. Acknowledgment of financial responsibility

By my signature below, I understand that it is my **responsibility** to supply the clinic with current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a **routine diagnosis** my insurance may **not cover the examination**. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered. I am aware that I am **responsible for any unpaid** balances. I authorize the clinic to charge my credit card on file or send an invoice for any outstanding balance. If my account results in collection agency involvement, the undersigned, guarantor receive all payments for services rendered to me or my dependents. I understand that a **No-Show or Non-Cancellation** at least 6 hours before appointment time will result in a **$10 fee** charged to your account.

By my signature below, I agree to all of the above while I am a patient of the Clinic.

_____ _____

Signature **Date**

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signature of guardian:

_____ _____

Signature of Guardian **Date**

Medical Record Request

Patient Name: _____

Date of Birth: ___/____/____

I authorize the release of my Medical Records or other Health Care information including Intake Forms, Chart notes, Reports, Correspondence, Care Plans, Pathology Reports, Radiology Reports, Operative Reports, Lab Reports and/or other written Information concerning the Patients Health and Treatment during any Period to be sent to the following Practice

Shenango Spine Center

2540 New Butler Road, Suite 201

New Castle, PA 16101

Phone: 724-856-8390

Fax: 724-856-8573

Date: ___/___/___

Patient Signature: _____

Printed Name of Patient

Representative: _____

Signature of Patient

Representative: _____

Patient Health Questionnaire

Patient Name _____ AGE: _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

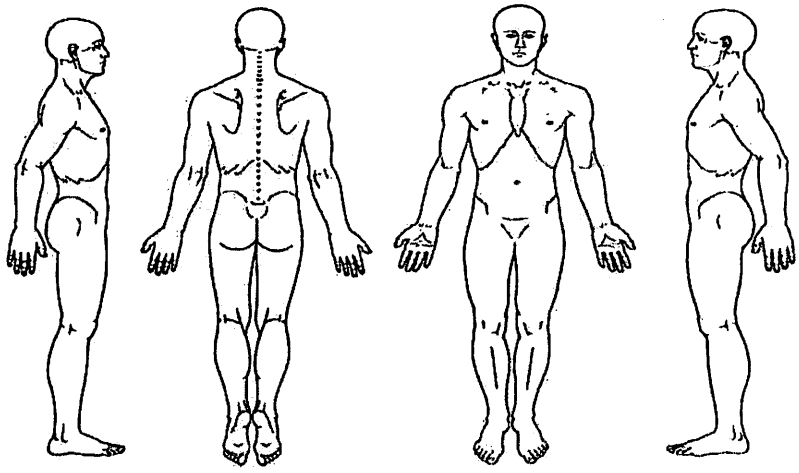
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										*Unbearable*
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____
② MRI *date:* _____
③ CT Scan *date:* _____
④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Low Back Pain	O	O	Angina	O	O	Smoking/Use Tobacco Products
						O	O	Drug/Alcohol Dependence
O	O	Shoulder Pain	O	O	Kidney Stones			
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Depression
O	O	Hand Pain	O	O	Painful Urination	O	O	Systemic Lupus
			O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Dermatitis/Eczema/Rash
O	O	Knee/Lower Leg Pain				O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
			O	O	Loss of Appetite	***Females Only***		
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
			O	O	Ulcer	O	O	Hormonal Replacement
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Pregnancy
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	
O	O	Rheumatoid Arthritis						
			O	O	Cancer	***Other Health Problems/Issues***		
O	O	General Fatigue	O	O	Tumor	O	O	
O	O	Muscular Incoordination				O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

_____

Patient Signature ***Date*** _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

The Primary Care Low Back Disability Questionnaire (PCLBDQ)

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) / /
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please **circle the choice which most closely describes your problem.**

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is very severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weight without pain.
B. I can lift heavy weight, but it gives me pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table.
E. Pain prevents me from lifting heavy weights, but can manage light-medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain on standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed but it doesn't prevent me from sleeping well.
C. Because of my pain my normal night's sleep is reduced by <¼.
D. Because of my pain my normal night's sleep is reduced by <½.
E. Because of my pain my normal night's sleep is reduced by <¾.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted by social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening

Office Use Only PCLBDQ SCORE: _____

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature_____ Date_____

With permission: Hudson-Cock N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Mailing address:
Landmark Healthcare, Inc., 1750 Howe Avenue, Suite 300, Sacramento, CA 95825