



Anne Langford, DC, DICCP ■ Heather Karls, DC, CCSP ■ Jessica Eliason, DC ■ Victoria Nelson, DC

### **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

#### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **04/14/2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

#### **Uses and Disclosures of Health Information**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, assist in the notification of (including identifying or location) a family member, you personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

### **Patient Rights**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.10 for each page. \$0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternatives means or location, and provide satisfactory explanations of how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

### **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact Officer: Anne Langford, DC

Telephone: 651-699-8610

I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES INFORMATION

\_\_\_\_\_  
Patient Name:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature:

\_\_\_\_\_  
Date

Relationship to Patient if unable to sign: \_\_\_\_\_



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## CONSENT TO TREAT A MINOR

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic treatment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the journal of the American Medical Association found that more than 2 million Americans become seriously ill each year from reactions to currently prescribed medications. 106,000 of those people die from the side effects.

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named \_\_\_\_\_, as the examining doctor deems necessary.

I understand the remote possibility of an injury to my child from a chiropractic treatment and elect him/her to receive the recommended treatment.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## **PAYMENT POLICY**

If your insurance policy provides for chiropractic services, this is our payment plan.

**LIMITED ASSIGNMENT:** We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15<sup>th</sup> of the month. **Copays are due at time of service.**

**If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) Payment is expected at the time of service.**

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Langford & Karls Chiropractic. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid, whether in full or partial, are considered delinquent. Payment plans are available. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of \$20.00 will be charged for any returned checks.

### **NO SHOW POLICY**

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of \$20.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

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Patient or Guardian Signature

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Date

## Acknowledgement of Financial Responsibility

### Non-Covered Services Disclosure Form

As your Doctors of Chiropractic, we want to provide you with the best possible care. There are services that we feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance coverage. You will be expected to pay for those services in full at the time of service. We want to assure you that we will only provide care that we feel is medically necessary.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical condition.
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services not covered include:

- Some Diagnostic Services
- Some Therapeutic services
- Some Durable Medical Products (braces, ice packs, ect.)
- Maintenance Care also known as Elective Care

Future dates of service:

It is our policy that if a patient has not received care in **six months or longer** we are required to do an re-examination prior to treatment. This updated information gives us a better understanding on a patient's current condition so we can properly administer an updated treatment plan.

I acknowledge that I am signing this statement voluntarily and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the billed charge(s) related to the non-covered services.

Non-covered services **may** include but are not limited to:

- |                                   |  |
|-----------------------------------|--|
| - Acupuncture: \$45.00            | - 1 <sup>st</sup> Day examination: \$70.00 |
| - Electrical Stimulation: \$25.00 | - Re-examination: \$50.00                  |
| - Cold Laser Treatment: \$25.00   | - X-Ray: \$34.00-\$100.00                  |
| - Ultrasound Therapy: \$25.00     | - Kinesiotape: \$25.00                     |

Maintenance/Elective Care is never covered and may also be determined by your health insurance and not Langford & Karls Chiropractic Clinic.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### PEDIATRIC NEW PATIENT INFORMATION

Date: \_\_\_\_\_

#### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Patient Nickname: \_\_\_\_\_

Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Patient's Social Security #: \_\_\_\_\_

Patient's Phone #: \_\_\_\_\_

Patient's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How were you referred to Langford Chiropractic Clinic? \_\_\_\_\_

#### FAMILY INFORMATION

Parent's name(s): \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Siblings Names & Ages: \_\_\_\_\_

Predominant Language Used at Home: \_\_\_\_\_

#### INSURANCE INFORMATION (Proof of Insurance is Required)

Primary Insurance Name: \_\_\_\_\_ Policy ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Policy ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**SCHOOL-AGE CHILD HISTORY**  
**6 years and Older**

**ABOUT YOUR LIFESTYLE**

What grade are you in at school? \_\_\_\_\_

How do you carry your school books? \_\_\_\_\_

How heavy is your school book bag? \_\_\_\_\_

What sports do you play? \_\_\_\_\_

What hobbies do you have? \_\_\_\_\_

How many hours each day do you watch TV? \_\_\_\_\_

How many hours each day do you spend using a computer? \_\_\_\_\_

How often do you play video games? \_\_\_\_\_

On average, how many hours sleep do you get each night? \_\_\_\_\_

Are there any smokers in your family? \_\_\_\_\_

Do you feel stressed out? \_\_\_\_\_

Do you have trouble reading the board in class? \_\_\_\_\_

Do you ever have blurred vision? \_\_\_\_\_

Do you wear glasses or contact lenses? \_\_\_\_\_

Do you sometimes get headaches when you read? \_\_\_\_\_

**ABOUT YOUR DIET**

What do you usually eat for Breakfast? \_\_\_\_\_

What do you usually eat for Lunch? \_\_\_\_\_

What do you usually eat for Dinner? \_\_\_\_\_

What snacks do you have after school? \_\_\_\_\_

What is your favorite food? \_\_\_\_\_

How much water do you drink each day? \_\_\_\_\_

How many sodas or colas do you drink each day? \_\_\_\_\_

How often do you eat fast food items? \_\_\_\_\_



**SCHOOL-AGE CHILD HISTORY**  
**6 years and older**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Sex: M F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

When did this problem first occur? \_\_\_\_\_

Yes No  
  Have you ever had this problem before? \_\_\_\_\_

Yes No  
  Have you previously been treated for this problem? Doctor's name \_\_\_\_\_

Yes No  
  Have you previously been to a chiropractor? When? \_\_\_\_\_

**ABOUT YOUR HEALTH**

In the past year have you had any of the following?

Yes No  
  Back or neck pain? \_\_\_\_\_

Yes No  
  Pains in the legs or arms? \_\_\_\_\_

Yes No  
  Headaches? \_\_\_\_\_

Yes No  
  Asthma? \_\_\_\_\_

Yes No  
  Allergies? \_\_\_\_\_

Yes No  
  Earaches? \_\_\_\_\_

Yes No  
  Falls from a bicycle, skateboard, scooter, rollerblades or similar? \_\_\_\_\_

Yes No  
  Do you ever have a problem with bedwetting? \_\_\_\_\_

Yes No  
  Have you ever been in a motor vehicle accident? \_\_\_\_\_

Yes No  
  Have you ever had any broken bones? \_\_\_\_\_

Yes No  
  Have you ever had any surgeries? \_\_\_\_\_

Yes No  
  Are you at present taking any medications? \_\_\_\_\_

Yes No  
  Do you have any other health problems? \_\_\_\_\_