Langford & Karls
CHIROPRACTIC
YOUR FOUNDATION FOR HEALTH

Anne Langford, DC, DICCP • Heather Karls, DC, CCSP • Jessica Eliason, DC • Victoria Nelson, DC • Brittany Schmidt, MHS, 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 disclosers. 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 handles 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 t 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

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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: _____

Please Turn Over

730 Cleveland Avenue South, Saint Paul, MN 55116 • Phone: 651.699.8610 • Fax: 651.699.1207 • www.langfordchiropractic.com

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 ASSIGNEMENT: 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 15th 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.

_____ _____

Patient or Guardian Signature Date

Please Turn Over

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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 policy. 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, etc.)
- 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 a re-examination prior to treatment. This updated information gives us a better understanding of 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
- Electrical Stimulation: $25.00
- Cold Laser Treatment: $25.00
- Ultrasound Therapy: $25.00
- 1st Day examination: $100.00
- Re-examination: $60.00
- Kinesiotape: $35.00

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: _____

NEWBORN TO CHILD HISTORY – BIRTH TO 5 YEARS

Today's date _____ Height: _____ Weight: _____ Age: _____

Patient's Name_____ Sex: M F Date of Birth: _____

Reason for Today's Visit_____

The following questions are designed to help the doctor provide the best possible care for your child.

[x] If yes, and please describe.

Feeding/Nutrition

- ☐ Does your child have any feeding difficulties? _____
- ☐ Is the baby breast fed? If no, for how long was baby breast fed_____ weeks/months
  - o Does baby have a one sided breast-feeding preference? Y / N Preferred breast Left / Right
- ☐ Is baby formula fed? Which formula or other milk source? _____
- ☐ Does baby frequently spit-up after feeding? _____
- ☐ Is your child eating solid food? What foods does his/her diet contain? _____
  - o What does your child usually eat for Breakfast? _____
  - o What does your child usually eat for Lunch? _____
  - o What does your child usually eat for Dinner? _____
  - o What does your child usually eat for Snacks? _____
- ☐ What is your child's favorite foods? _____
- ☐ Is your child receiving any vitamin supplements? _____
- ☐ Does your child have any food allergies? _____
- ☐ Does your child have any persistent or intermittent skin rashes? _____
- ☐ Do you have any concerns about your child's diet? _____

Sleeping

- ☐ Does your child go to sleep easily? _____
- ☐ Does your child have a preferred sleeping position? _____
- ☐ Does your child cry if you change this sleeping position? _____
- ☐ How much sleep is your child getting? _____ hours/night Naps _____ hours during the day

Digestion

- ☐ Does your child pass a lot of intestinal gas? _____
- ☐ Does your child have any digestive disturbances? _____
- ☐ Does your child eliminate stools each day? If no, how often_____/week

Trauma

- ☐ Has your child had any recent falls or trauma? _____
  - o Describe the trauma and the date it occurred _____
- ☐ Has your child been in a car accident or near-miss? _____
- ☐ Has your child ever had a bone fracture or dislocation? _____
- ☐ Has your child had any other trauma or injuries? _____
- ☐ Does your child ever complain of back or neck pain? _____
- ☐ Does your child ever complain of pains in legs or arms? _____
- ☐ Does your child ever complain of headaches? _____
- ☐ Does your child complained of pain or discomfort? If yes, when did this occur? _____
- ☐ Was onset Sudden / Gradual ☐ Is problem Constant / Intermittent
- ☐ Has your child ever had this problem before? _____

Health History

- ☐ Does your baby cry a lot? For how many hours _____ /day? _____
- ☐ Does your child ever bang his/her head against a wall, bed or other object? _____
- ☐ Does your child have a preferred head position? _____
- ☐ Does your child frequently arch his/her head and neck backwards? _____

- ☐ Does baby cry or become irritable during a diaper change? _____
- ☐ Has your child previously been treated for this problem? By whom? _____
- ☐ Has your child previously had chiropractic care? Previous chiropractor _____
- ☐ Has your child had a fever? At what age did the child's first earaches occur? _____
- ☐ Has your child had asthma? _____
- ☐ Is your child allergic to anything? _____
- ☐ Are there any smokers in the child's home? _____
- ☐ Has your child had any earaches? At what age did the child's first earaches occur? _____
  - o How frequently does your child have earaches? _____ Which ear? Right / Left / Both
- ☐ Is your child taking any prescription medications? _____
- ☐ Has your child been vaccinated? _____
- ☐ Do you have any other concerns about your child's health? _____

Please list any other illness which have been a concern for your child

_____

Please list any surgeries your child has had

_____

Pregnancy history

Mother's Name_____ How many children do you have? _____

What was the term of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA?	☐	☐	_____
High B.P.?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning sickness?	☐	☐	_____
Indigestion?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen ankles?	☐	☐	_____
Thyroid problems?	☐	☐	_____
Heart problems?	☐	☐	_____
Back pain?	☐	☐	_____
Abnormal bleeding?	☐	☐	_____
Were you hospitalized?	☐	☐	_____
Any other illnesses?	☐	☐	_____

DURING YOUR PREGNANY, DID YOU USE ANY OF THE FOLLOWING:

Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication _____ Reason _____
Over-the-counter meds?	☐	☐	Medication _____ Reason _____

Signature: _____ Date: _____