Langford & Karls CHIROPRACTIC
YOUR FOUNDATION FOR HEALTH

Village ACUPUNCTURE MASSAGE

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

Langford & Karls
CHIROPRACTIC
YOUR FOUNDATION FOR HEALTH

Anne Langford, DC, DICCP • Heather Karls, DC, CCSP • Jessica Eliason, DC

I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES INFORMATION

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to patient if unable to sign: _____

Consent to Share Confidential Information (optional):

In adherence with HIPAA, Langford & Karls Chiropractic will not share any information regarding appointment times, insurance/billing information, health history, etc. with anyone including your spouse, parent, or other family members unless you provide consent below.

I, _____, provide consent for Langford & Karls Chiropractic to share my confidential information with the following individuals. I understand that I may revoke this consent in writing at any time:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Patient Signature: _____ Date: _____

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 policy.

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 which will include the portion that you owe. Balances are due within 30 days after receiving your statement. **Copays are due at time of service.**

If you do not have chiropractic coverage or prefer not to go through your insurance plan, we also offer a same-day payment plan that is available to all of our patients which offers discounted rates for patients who pay out of pocket. ***Please note that the same-day payment plan must be chosen by the patient prior to billing insurance and that services not paid for on the same day of service will be charged at the full price.***

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 may 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 may 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

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**
- **Non-Spinal Adjustment: $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: _____

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? _____

_____

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? _____

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PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient Nickname: _____

Sex: M / F Date of Birth: _____ Height/Weight: ____ Patient's Social Security #: _____

Patient's Phone #: _____

Patient's Home Address: _____

City: _____ State: _____ Zip: _____

How were you referred to Langford Chiropractic Clinic? _____

Contact preference: _____ Reason for Visit: _____

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: _____