Standard

WELCOME!

We are happy to serve you. If you EVER have any concerns or questions, please do not hesitate to ask!

Attached are several forms for you to fill out to the best of your ability. It can be tedious, but please take your time, we want the best outcome for you and the least irritations after we get started. If we can get this out of the way at the beginning then we can just concentrate on getting you well again!

- **Chief Complaint** - There are two copies of this form, please fill out one form for each major complaint. If you have more than two major problems please feel free to print more. Some problems may be obviously related, in which case feel free to put them both on the same sheet.
- **Health History** - Please fill out to the best of your ability, it gives us some idea of what has gone on before the accident.
- **Financial Policy & Agreement** - This lays out our financial policies.
- **HIPAA Privacy Notice & Consent** - Describes how private information about you may be used and disclosed and how you can get access to this information.
- **Informed Consent** - Legal requirement informing you of the risks inherent in receiving or not receiving care in our office.
- **Authorization to Use or Disclose (Release) Personal Health Information for Blair Chiropractic Clinic Research Studies**.

The best procedure is to print these out, fill them out, and bring them with you on your next visit. Please do not email them. Email is not considered secure enough to transmit private healthcare information. If you wish to get these forms into our hands before your visit you may drop them by (call first to make sure we are here) or fax them to (806) 702-4924.

If you have any other information from other doctors or healthcare services that you think may be pertinent to your case (including x-rays, cat scans, MRI reports, etc), please bring them to your first appointment as well.

Yours in Health,

Gordon D. Elder, DC, FICPA

Gordon D. Elder, DC, Director

Certified Advanced Blair Technique Instructor *Fellow of the International Chiropractic Pediatric Association*

1802 E 50th St, Ste 112, Lubbock TX, 79404 (806) 747-2735 office@BlairClinic.com

www.BlairClinic.com

CHIEF COMPLAINT

Date: _____

Full Legal Name: _____

Please fill this out, ***one sheet for each problem or group of problems****. Answer as best you can. There are two sides.*

Problem: _____

- How and/or when did it start? _____

  _____

- Have you ever had it before? _____
- Have you ever been injured here before? _____
- Where is it exactly? _____
- Does it radiate to or affect other parts of your body? _____
- How often does it occur? *(circle one)* ***10% 20% 30% 40% 50% 60% 70% 80% 90% 100%*** of the time.
- When does it occur (AM/PM/Month/Year/activity, etc)? _____

  _____

- How long does it last? _____
- Describe how it feels: (*circle all that apply)* ***sharp dull aching throbbing crushing stabbing burning stiff numb tingling sore***

  other: _____
- Please rate the discomfort on a scale of 0-10, with THREE CIRCLES for best, worst and average, 10 being worst possible discomfort, 0 being none (7 is severe enough you are thinking about going to the hospital):

  0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10. What level is it at right now? _____
- What triggers it or makes it worse? (*circle all that apply)* ***sitting lifting bending standing walking lying reaching***

  other: _____
- What makes it feel better? _____
- How is it affecting you at home? _____

  At work? _____

  During outside activity? _____
- What have you done for this already? Doctors you have seen, treatments you have received, home remedies, etc: _____

  _____

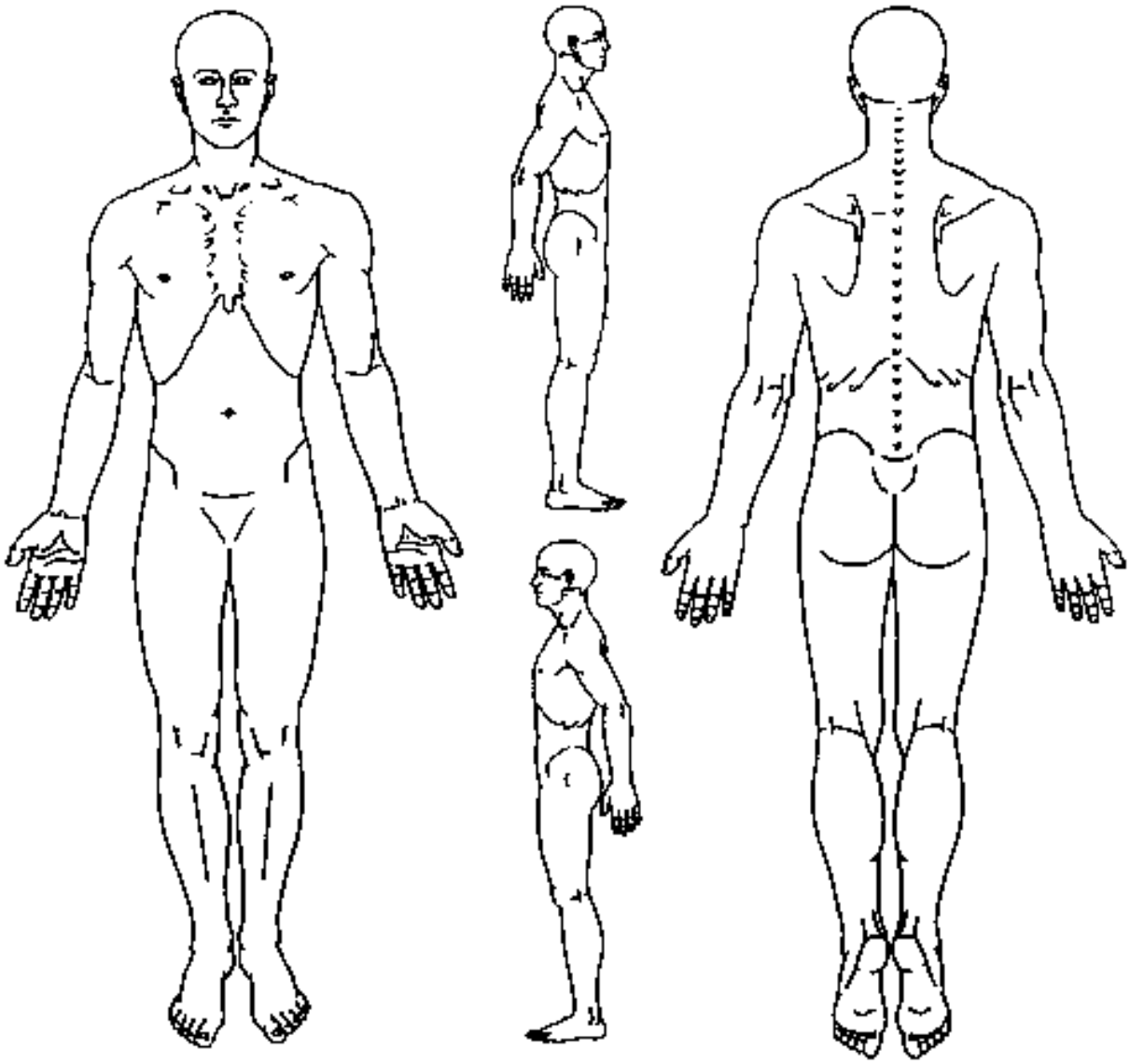
Signature: _____ Date: _____

Name: _____

Symptom described on previous page: _____

On the diagram below, please indicate where you are experiencing pain or other symptoms.

A = Ache B = Burning S = Stabbing N = Numbness T = Tingling C = Crushing Th = Throbbing St = Stiff O = Other



Signature: _____ Date: _____

CHIEF COMPLAINT

Date: _____

Full Legal Name: _____

Please fill this out, ***one sheet for each problem or group of problems****. Answer as best you can. There are two sides.*

Problem: _____

- How and/or when did it start? _____

  _____

- Have you ever had it before? _____
- Have you ever been injured here before? _____
- Where is it exactly? _____
- Does it radiate to or affect other parts of your body? _____
- How often does it occur? *(circle one)* ***10% 20% 30% 40% 50% 60% 70% 80% 90% 100%*** of the time.
- When does it occur (AM/PM/Month/Year/activity, etc)? _____

  _____

- How long does it last? _____
- Describe how it feels: (*circle all that apply)* ***sharp dull aching throbbing crushing stabbing burning stiff numb tingling sore***

  other: _____
- Please rate the discomfort on a scale of 0-10, with THREE CIRCLES for best, worst and average, 10 being worst possible discomfort, 0 being none (7 is severe enough you are thinking about going to the hospital):

  0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10. What level is it at right now? _____
- What triggers it or makes it worse? (*circle all that apply)* ***sitting lifting bending standing walking lying reaching***

  other: _____
- What makes it feel better? _____
- How is it affecting you at home? _____

  At work? _____

  During outside activity? _____
- What have you done for this already? Doctors you have seen, treatments you have received, home remedies, etc: _____

  _____

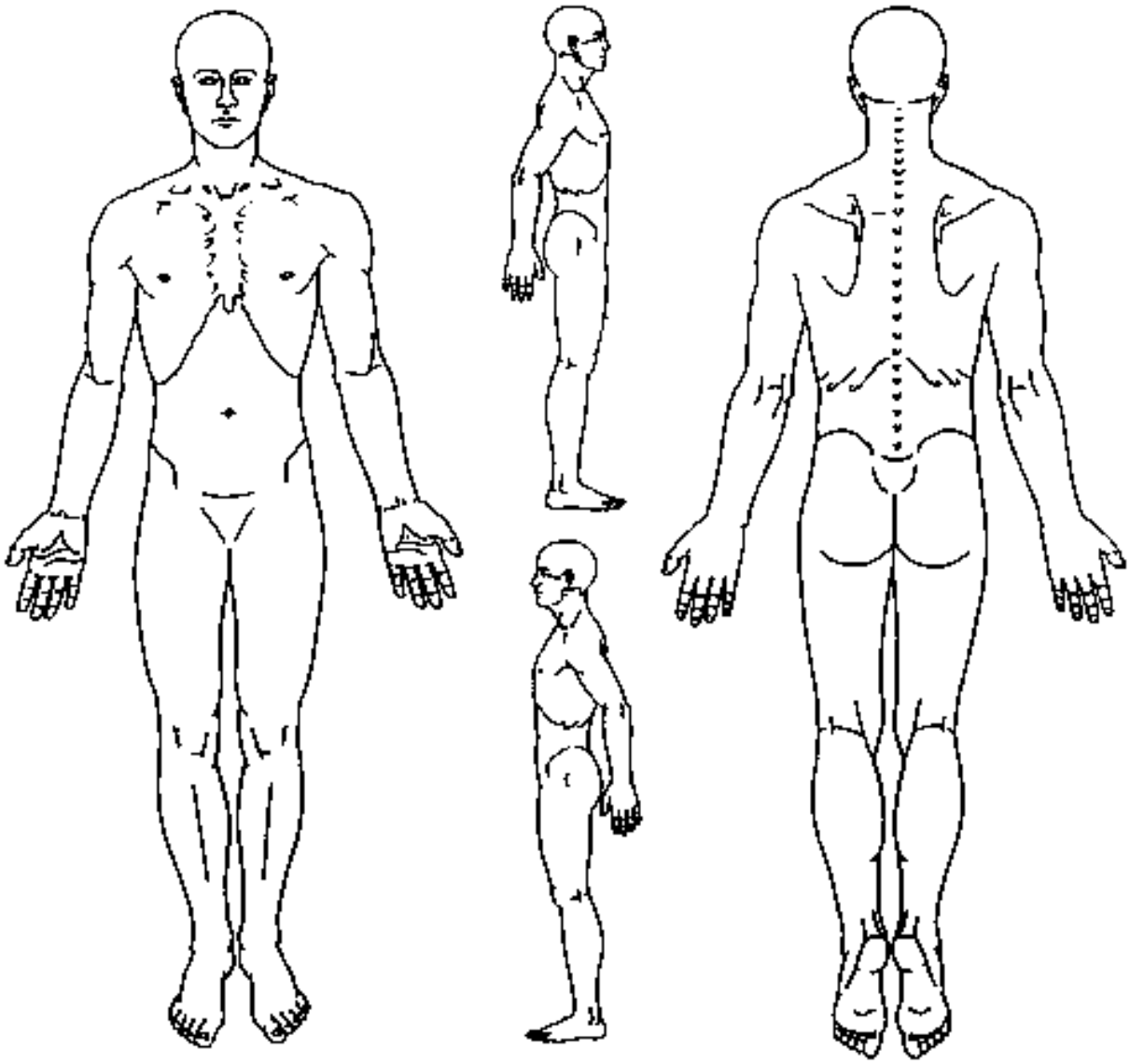
Signature: _____ Date: _____

Name: _____

Symptom described on previous page: _____

On the diagram below, please indicate where you are experiencing pain or other symptoms.

A = Ache B = Burning S = Stabbing N = Numbness T = Tingling C = Crushing Th = Throbbing St = Stiff O = Other



Signature: _____ Date: _____

HEALTH HISTORY

Date: _____

Full Legal Name: _____

GENERAL HEALTH: please answer to the best of your ability.

Do any of the following apply to you as far as you know (please mark YES or NO for EACH condition):

Yes No Articular Hypermobility Disease
Yes No Severe demineralization of bone
Yes No Benign bone tumor in the spine
Yes No Bleeding disorder
Yes No Anticoagulant therapy?
Yes No Radiculopathy with progressive neurological signs
Yes No Radiating pain, numbness or weakness in upper extremities
Yes No Radiating pain, numbness or weakness in lower extremities

Yes No Rheumatoid Arthritis
Yes No Ankylosing Spondylitis
Yes No Fracture(s) _____
Yes No Dislocation(s) _____
Yes No Unstable Os Odontoideum
Yes No Malignancies that involve the vertebral column
Yes No Infection of bones or joints of the vertebral column
Yes No Myelopathy
Yes No Cauda Equina Syndrome
Yes No Vertebrobasilar Insufficiency Syndrome
Yes No Major artery aneurysm

List auto accidents or personal injuries with years: _____

_____

List other surgeries, hospitalizations, operations with years: _____

_____

List other previous major illnesses or injuries: _____

_____

Do you wear: __Heal Lifts __Sole Lifts __Inner Soles __Arch Supports __None

Have you ever (please mark YES or NO for EACH question and supply details for each YES):

Yes No Been knocked unconscious? _____
Yes No Used a cane, crutch or other support? _____
Yes No Been treated for a spine or nerve disorder? _____
Yes No Had a fractured bone? _____

Medications you are currently taking and what they are for (prescription or non-prescription):

___ High Blood Pressure: _____ ___ Cholesterol: _____
___ Pain: _____ ___ Arthritis: _____
___ ADD/ADHD: _____ ___ Insulin: _____
___ Other: _____

List any known allergies: _____

FAMILY HEALTH: please answer to the best of your ability (for your parents, siblings and children).

Health status of family members: _____

_____

Are there any immediate family members that suffer from:
__Stroke __Heart condition __Cancer/Tumor __Degenerative Disk Disease __Osteoporosis __Arthritis
__Any other potentially familial conditions: _____

SOCIAL HISTORY: tell us a little more about your lifestyle.

Education: __High School __Some College __College Grad __Post Grad
Daily Activities: __Sitting __Standing __Light Labor __Heavy Labor __Computer
Hobbies: _____

HEALTH HISTORY

Habits:	Heavy	Mod.	Light	None
Alcohol	____	____	____	____
Caffeine	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____

	Heavy	Mod.	Light	None
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

REVIEW OF SYSTEMS:

Please check the appropriate box **(O)ccasional, (F)requent, (C)onstant** for any of the following symptoms which you now have or have had previously.

O F C GENERAL __None
_ _ _ Allergy
_ _ _ Chills
_ _ _ Convulsions
_ _ _ Dizziness
_ _ _ Fainting
_ _ _ Fatigue
_ _ _ Fever
_ _ _ Headache
_ _ _ Loss of sleep
_ _ _ Loss of weight
_ _ _ Nervousness / Depression
_ _ _ Neuralgia
_ _ _ Numbness
_ _ _ Sweats
_ _ _ Tremors

O F C MUSCLE AND JOINT __None
_ _ _ Arthritis
_ _ _ Bursitis
_ _ _ Foot trouble
_ _ _ Hernia
_ _ _ Low back pain
_ _ _ Lumbago
_ _ _ Neck pain / stiffness
_ _ _ Pain between shoulders
_ _ _ Pain / Numbness in shoulders
_ _ _ Pain / Numbness in arms
_ _ _ Pain / Numbness in elbows
_ _ _ Pain / Numbness in hands
_ _ _ Pain / Numbness in hips
_ _ _ Pain / Numbness in legs
_ _ _ Pain / Numbness in knees
_ _ _ Pain / Numbness in feet
_ _ _ Painful joints
_ _ _ Poor posture
_ _ _ Sciatica
_ _ _ Spinal curvature / scoliosis
_ _ _ Swollen joints

O F C GASTRO-INTESTINAL __None
_ _ _ Belching or gas
_ _ _ Colitis
_ _ _ Colon trouble
_ _ _ Constipation
_ _ _ Diarrhea
_ _ _ Difficult digestion
_ _ _ Distension of abdomen
_ _ _ Excessive hunger
_ _ _ Gall bladder trouble
_ _ _ Hemorrhoids
_ _ _ Intestinal worms
_ _ _ Jaundice
_ _ _ Liver trouble
_ _ _ Nausea
_ _ _ Pain over stomach
_ _ _ Poor appetite
_ _ _ Vomiting
_ _ _ Vomiting blood

O F C EENT __None
_ _ _ Asthma
_ _ _ Colds
_ _ _ Crossed Eyes
_ _ _ Deafness
_ _ _ Dental Decay
_ _ _ Earache
_ _ _ Ear discharge
_ _ _ Ear noises
_ _ _ Enlarged glands
_ _ _ Enlarged thyroid
_ _ _ Eye pain
_ _ _ Failing vision
_ _ _ Farsightedness
_ _ _ Gum trouble
_ _ _ Hay fever
_ _ _ Tonsillitis
_ _ _ Hoarseness
_ _ _ Nasal Obstruction
_ _ _ Nearsightedness
_ _ _ Nosebleeds
_ _ _ Sinus infection
_ _ _ Sore throat

O F C CARDIOVASCULAR __None
_ _ _ Hardening of arteries
_ _ _ High blood pressure
_ _ _ Low blood pressure
_ _ _ Pain over heart
_ _ _ Poor circulation
_ _ _ Rapid heart beat
_ _ _ Slow heartbeat
_ _ _ Swelling of ankles

O F C RESPIRATORY __None
_ _ _ Chest pain
_ _ _ Chronic cough
_ _ _ Difficult breathing
_ _ _ Spitting up blood
_ _ _ Spitting up phlegm
_ _ _ Wheezing

O F C SKIN __None
_ _ _ Boils
_ _ _ Bruise easily
_ _ _ Dryness
_ _ _ Hives or allergy
_ _ _ Itching
_ _ _ Skin eruptions (rash)
_ _ _ Varicose veins

O F C GENITOURINARY __None
_ _ _ Bed-wetting
_ _ _ Blood in urine
_ _ _ Frequent urination
_ _ _ Inability to control urination
_ _ _ Kidney infection
_ _ _ Painful urination
_ _ _ Prostate trouble

O F C WOMEN ONLY __None
_ _ _ Congested breasts
_ _ _ Cramps or backache
_ _ _ Excessive menstrual flow
_ _ _ Hot flashes
_ _ _ Irregular cycle
_ _ _ Lumps in breast
_ _ _ Menopause symptoms
_ _ _ Painful menstruation
_ _ _ Vaginal discharge

ARE YOU PREGNANT? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize the Blair Chiropractic Clinic to provide me with chiropractic care, in accordance with State statutes.

Patient Signature: _____ Date: _____

I have reviewed this form. Doctor's Signature: _____ Date: _____

Financial Policy & Agreement

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic located at 1802 50th St E, Ste 112, Lubbock, TX 79404. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should, therefore, be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply

the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of the same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (please print): _____

Signature: _____ Date: _____

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic
1802 E 50th Street Ste 112 Lubbock, TX 79404
(806) 747-2735

Notice of Privacy Practices
Your Rights & Our Responsibilities

EFFECTIVE: June 1, 2021

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a ***Request to Inspect or Copy Patient Information*** form (also referred as a ***Patient Records Request*** form). The form contains the contact information of our compliance officer, and any related fees for copying your records. NOTE: Portions of an Electronic Health Record (if applicable) may be available via an on-line portal or other healthcare exchange. This will be noted in the request form.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws regarding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the ***Request to Amend Patient Record*** form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days.

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email.
- Request alternative communications; you must make your request in writing to our privacy office, a ***Request for Alternative Communications*** form will be provided upon request.

Ask us to limit or restrict the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a ***PHI Use and Disclosure Authorization*** form will be provided, upon request.
- Restrict payer access. 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. You must make your request in writing to our privacy office; a ***Request to Restrict Disclosure to Health Plan*** form will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing. A ***Request for Accounting of Disclosure*** form will be provided upon request. In turn you will receive a ***Response to Request for Disclosure*** form. The first accounting of disclosure request within a 12 month period will be at no cost. Additional request within that time period, will result in a charge based on the reasonable costs for providing accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer also referred to as compliance officer; we will supply you with a ***Complaint*** form upon request (form contains the name of our privacy official and his/her contact information).
- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- 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, call-ing 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

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate 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 will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and pre-certification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third-party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence ; reporting disease or other required data in compliance with state and federal laws.
- Communicating with healthcare exchanges and networks according to federal and state laws with regards to Right of Access and interoperability regulations.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
  If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative. To include communication with medical examiner and or funeral director (if applicable).

Other

- Text reminders
- Product offers
- Medical tips and suggestions

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
  We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.
- To provide you with notice, such as this Notice of Privacy Practices and abide by the terms of our most current Notice of Privacy Practices.
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

- We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised Notice of Privacy Practices will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices. If you have limited proficiency in English, you may request a Notice of Privacy Practices in Spanish

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____

(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Driver's License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Attempt 1 Date _____ Staff_____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Attempt 2 Date _____ Staff _____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members about appointments, and test results.
- ❑ Leave messages on work phone about appointments, and test results.
- ❑ Leave messages on cell phone about appointments, and test results.
- ❑ Email appointment reminders
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic disclosure of my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by the clinic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative **Date**

Relationship to Patient: _____Driver's License Number: _____State____

Informed Consent

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The treatment used to help people by Doctors of Chiropractic is the chiropractic adjustment, also called spinal manipulative therapy. The purpose of a chiropractic adjustment is to correct a subluxation or slight joint dislocation that is affecting nerves and thereby adversely affecting the health and function of the body. The adjustment may cause an audible "pop" or "click." The upper-cervical specific adjustment primarily used in this office does not involve any twisting and generally is not accompanied by any joint noise.

Analysis / Examination / Correction: As a part of the analysis, examination, and correction you are consenting to the following procedures as needed:

- chiropractic adjustment
- palpation
- range of motion testing
- orthopedic testing
- neurologic testing
- postural analysis
- radiographic studies (x-rays/CT scans)

The material risks inherent in chiropractic adjustments: As with any healthcare procedure, there are certain complications that may arise during chiropractic adjustments. Some patients will feel some stiffness and soreness due to changes in spinal alignment. Other possible complications include but are not limited to fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains, and separations. In addition, some types of manipulation of the neck have been associated with injuries of the arteries in the neck leading to or contributing to serious complications including stroke. Every reasonable effort to screen for contraindications to care will be made; if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which should be discovered during the history, examination or x-ray portion of your initial visits. Stroke has been the subject of tremendous disagreement, they are associated with rotational adjustments of the neck which are not performed in this office, and even then are exceedingly rare. Recent research suggests that strokes are no more likely after a rotational chiropractic adjustment than any other time. The other complications mentioned are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered over-the-counter pain medications and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Physical Therapy
- Surgery

If you choose to use one of the above listed "other treatment" options, you should be aware that there are risks and benefits to each option and you should discuss these with your primary medical physician.

The risks and dangers attendant to not correcting the subluxation: Remaining subluxated may allow the formation of joint adhesions and the reduction of mobility which may set up a pain reaction further reducing mobility. Furthermore, any neurologic disruption caused by the subluxation will not be removed and the areas controlled by those nerves will be weakened, diseased, or otherwise dysfunctional. Over time this process may complicate future correction, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related procedures. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the correction recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (please print): _____

Signature: _____ Date: _____

Doctor's Name: ▢ Dr. Elder ▢ Dr. Jensen ▢ Other: _____

Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Authorization to Use or Disclose (Release) Personal Health Information for Blair Chiropractic Clinic Research Studies

By signing below, I permit the Blair Chiropractic Clinic to use or disclose (release) my personal health information for research studies performed by the clinic or doctors. This signed notice gives the clinic permission to disclose my protected health information to researchers when:

a) their research has been approved by an institutional review board that has reviewed the research proposal and

b) established protocols are in place to ensure the privacy of my protected health information.

The information that may be used or disclosed for research purposes may include, but is not limited to, medical history, results of physical exams, lab or imaging results, information related to a particular condition or treatment.

I may withdraw this consent and authorization at any time. Even if I withdraw this authorization, the Blair Chiropractic Clinic may still use or disclose health information they have already obtained if necessary to maintain the integrity or the reliability of the current research.

To withdraw this authorization, I must do so in writing to the Blair Chiropractic Clinic.

This authorization does not have an expiration date.

____ Yes, I give the Blair Chiropractic Clinic permission to use my personal health information for research study purposes. I understand the type of information that may be used for research purposes, and this authorization may be withdrawn at any time. _____ (patient initials here)

____ No, I do NOT give the Blair Chiropractic Clinic permission to use my personal health information for research. _____ (patient initials here)

Patient Signature: _____ Date_____

Doctor Signature: _____ Date_____

Gordon D. Elder, DC, Director

Certified Advanced Blair Technique Instructor *Fellow of the International Chiropractic Pediatric Association*

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