M. G. Dodge
Chiropractic
Michelle G. Dodge, DC
8479 Ridge Road, Sodus, NY 14551 phone (315) 498-0243
7588 S. State Street, Lowville, NY phone (315) 376-8088 / fax (315) 376-8089

HIPAA FORM

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to Dr. Michelle Dodge. I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identities me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor.

The Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. The Chiropractor reserves the right to change the privacy practices that are describe in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

______________________________________ ______________________
Printed Name of Patient Date

MG Dodge Chiropractic
Michelle Gaebel Dodge, PC

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____________________ **Date of Birth:**_____________________

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of ______[MG Dodge Chiropractic]PC____________.

I understand that the Notice describes the uses and disclosures of my protected health information by___ MG Dodge Chiropractic, PC______________ and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

MG Dodge Chiropractic, PC: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MG Dodge Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons. We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes.

Change of Ownership.

In the event that MG Dodge Chiropractic is sold or merged with another

organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Dr. Michelle Dodge are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that MG Dodge Chiropractic amend your protected health information. Please be advised, however, that MG Dodge Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by MG Dodge Chiropractic.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

MG Dodge Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, MG Dodge Chiropractic is required by law to comply with this Notice.

MG Dodge Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Michelle Dodge or by calling this office at (315)498-0243. If Dr. Michelle Dodge and is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how MG Dodge Chiropractic has handled your health information should be directed to Dr. Michelle Dodge by calling the office.

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide MG Dodge Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice

____ Patient's Name (print)

____ Patient's Signature

____ Authorized Facility Signature

______________ Date

______________ Date

M. G. Dodge

Chiropractic

Michelle G. Dodge, PC

8461 Ridge Road, Sodus, NY 14551 phone (315) 498-0243

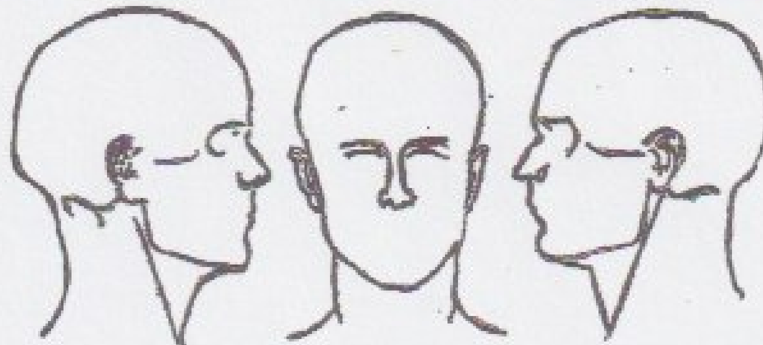
7588 S. State Street, Lowville, NY phone (315) 376-8088 / fax (315) 376-8089

Pain Drawing

Patient's Name: ______________________________

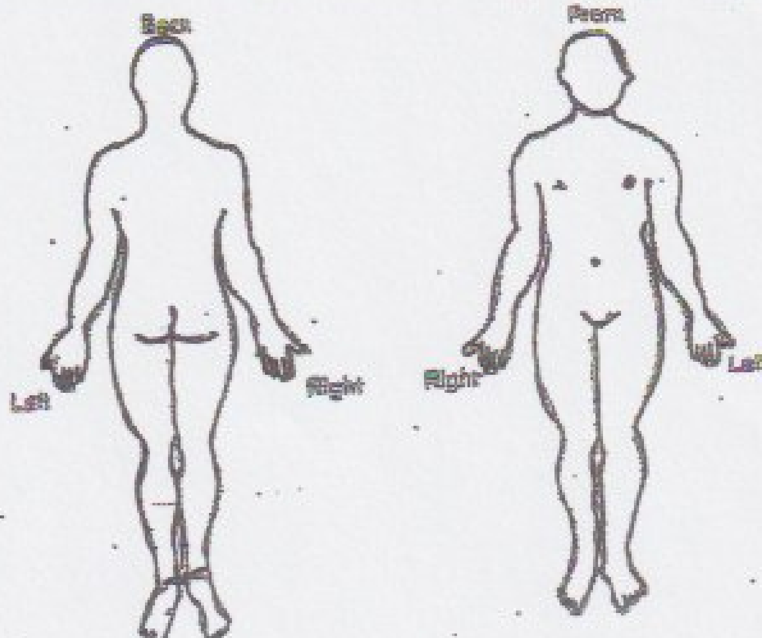
Draw the location of pain on body outlines and mark how mad it is on pain line at bottom of page. Please draw in your face.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^^^^^	========	ooooooooo	....	/////////	xxxxxxxx
^^^^^^^	========	ooooooooo	....	/////////	xxxxxxxx



No Pain |______________________________| Worst Pain Possible

Please make a slash through the above line as to the level of your pain.



No Pain |______________________________| Worst Pain Possible

Please make a slash through the above line as to the level of your pain.

Patient's Signature: ______________________ Date: ______________