MG Dodge Chiropractic,PC
Michelle Gaebel Dodge, DC

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 users 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 acknowledgement 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 acknowledgment
- ❑ Other (please specify):_____

MG Dodge Chiropractic, PC: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS 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 health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment

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

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 purpose 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 proceedings.

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 Donors

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 property of the new owner

Your Health Information Rights

1) You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however that Dr. Michelle Dodge is not required to agree to the restriction that you requested.

2) 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.

3) You have the 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.

4) You have a right to receive an accounting of disclosures of your protected health information made by MG Dodge Chiropractic.

5) You have the right to a paper copy of this Notice of 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 any questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Michelle Dodge. Our office phone (315) 498-0243. If Dr. Michelle Dodge 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.

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 disclose my protected health care information for the purposes of treatment, payment,and healthcare operations as described.

_____ Patient's Name (print)

_____ Patient's Signature

___/___/_____ Date

MG 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

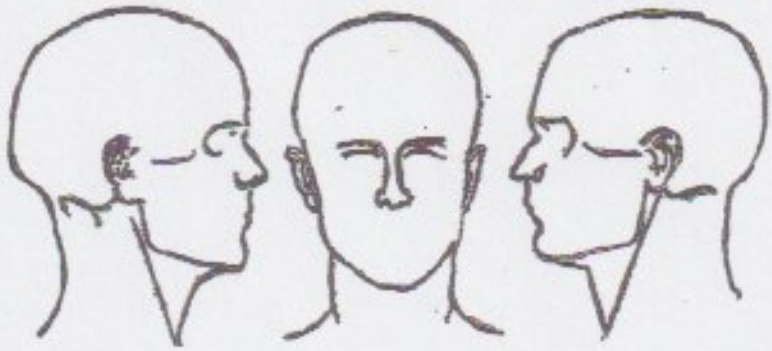
M. G. Dodge
Chiropractic
Michelle G. Dodge, PC
8461 Ridge Road, Sodus, NY 14551 phone (315) 498-0243
7588 S. State Street, Lowville, NY phone (315) 376-8088 / fax (315) 376-8089

Pain Drawing

Patient's Name: _____

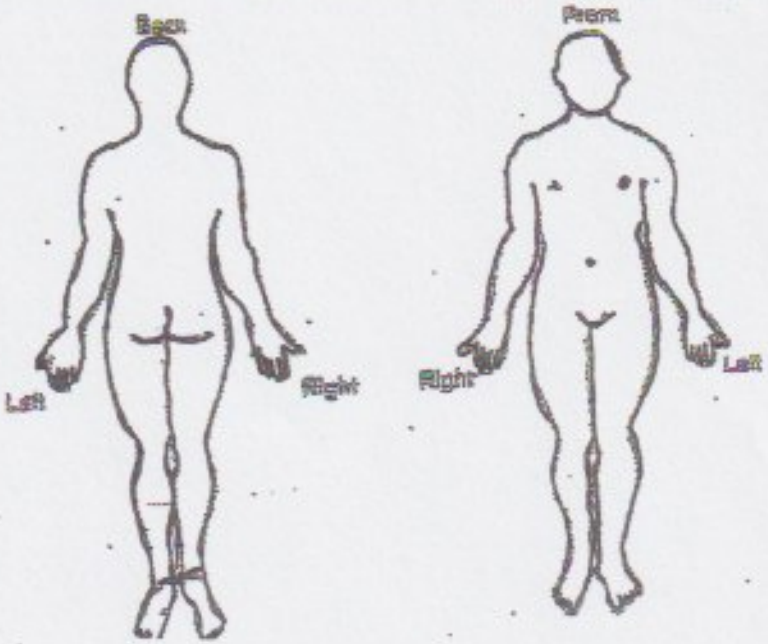
Draw the location of pain on body outlines and mark how mad it is on pain line at bottom of page. Please draw in your face.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^^^^^	========	oooooooooo	.....	//////////	xxxxxxxx
^^^^^^^	========	oooooooooo	.....	//////////	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: _____

MGDodge Chiropractic

Chiropractic Case History/Patient Information

Date:_____

Name:_____ Medicare #: _____ 'Home Phone _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ _____ _____

Age:_____ Birth Date: _____Marital: M S W D

Occupation:_____ Employer and address: _____

Spouse:_____ Spouse Birth Date:_____

Spouse employer and address:_____

_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case:

❒ Major Medical ❒ Worker's Compensation ❒ Medicaid ❒ Medicare ❒ Auto Accident
❒ Medical Savings Account & Flex Plans ❒ Other

Name of Primary Insurance Company and subscriber number: _____
Name of Secondary Insurance Company (if any)._____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Please understand that this chiropractic office does not participate with any insurance companies other than Medicare. We will bill your insurance company for you, however you must agree to either sign over any insurance check to us for services rendered in our office, or to bring a payment to us for the amount sent to you by your insurance company for services received in our office. If you have any questions regarding your insurances charges please bring in your EMB for an explanation of charges and payments.

PATIENT NAME _____

DATE _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ❒ Yes ❒ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

_____

Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ❒ Yes ❒ No

If yes, describe:_____

Do you have any allergies of any kind? ❒ Yes ❒ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____

CONTINUED

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

ADDITIONAL PERSONAL HEALTH GOALS

Check all that apply

_____ Weight Loss

_____ More Energy

_____Increased Performance

_____Healthy Aging

_____ Enhanced Mental Clarity

_____ Decrease Stress

_____Eliminate Bad Habits

_____Improve Lifestyle

PATIENT NAME _____

DATE _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

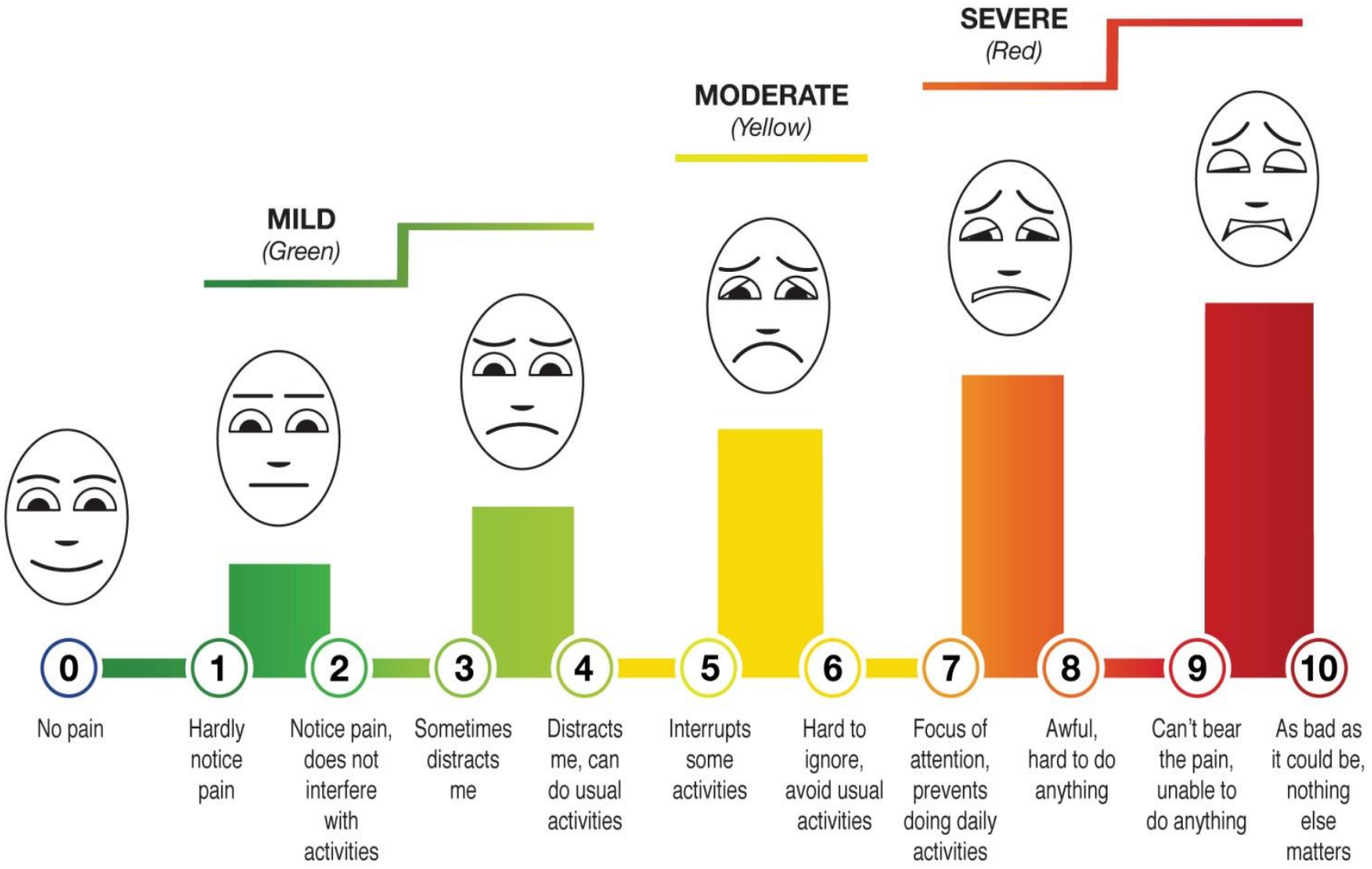
I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Defense and Veterans Pain Rating Scale



v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual <u>ACTIVITY</u>:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your <u>SLEEP</u>:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your <u>MOOD</u>:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your <u>STRESS</u>:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — Contributes a great deal

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.