



**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*

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**NOTICE TO PATIENT**

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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*

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**FOR OFFICE USE ONLY**

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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 identifies 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.

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Signature of Patient or Personal Representative

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Printed Name of Patient

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Date

M. G. Dodge

Chiropractic

Michelle G. Dodge, PC

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

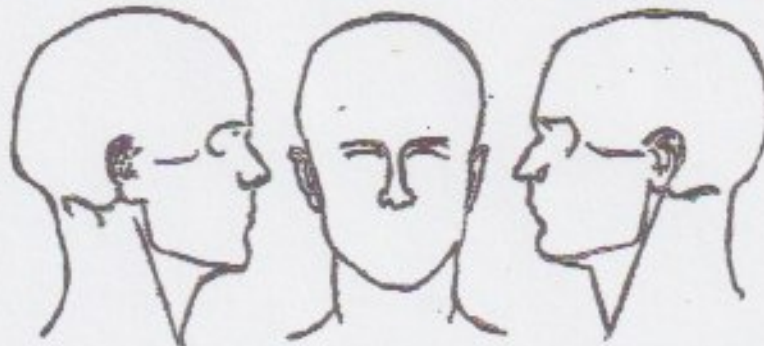
7588 S. State Street, Lowville, NY phone (315) 376-8088 / fax (315) 376-8089

**Pain Drawing**

Patient's Name: \_\_\_\_\_

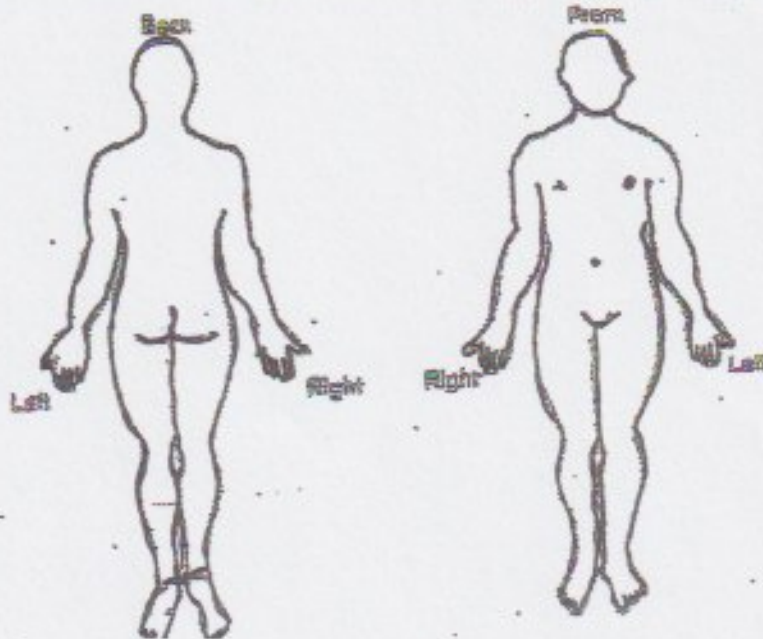
Draw the location of pain on body outlines and mark how mad it is on pain line at bottom of page. Please draw in your face.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
AAAAAAAAA	=====	OOOOOOOOO	.....	///////	XXXXXXXXX
AAAAAAAAA	=====	OOOOOOOOO	.....	///////	XXXXXXXXX



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: \_\_\_\_\_

## 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 insurance 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	_____	Alcoholism	_____
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	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

**ADDITIONAL PERSONAL HEALTH GOALS**

Check all that apply

_____ Weight Loss	_____ Enhanced Mental Clarity
_____ More Energy	_____ Decrease Stress
_____ Increased Performance	_____ Eliminate Bad Habits
_____ Healthy Aging	_____ 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	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	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:
 

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

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_