

# NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION



913 South College Road, Suite 105  
Lafayette, Louisiana, 70503  
337-261-0100  
Fax: 337-261-5589  
www.AbshireChiroSport.com

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

## USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your chiropractor or a staff member may have to disclose your health information, including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- 4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

## Our Privacy Pledge

We have an always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

## Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- 3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 5) We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

## Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(i)
- 2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:

Abshire Chiropractic Sports Center, L.L.C.  
913 South College Road, Suite 105  
Lafayette, Louisiana, 70503

## Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organization to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider. (over)

**Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

**Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

**Your right to amend your health information**

You have the right to request that we amend your health information for six years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

**Your right to receive an accounting of the disclosures we have made of your records**

Louisiana law requires that we furnish you, upon your request, a copy of any information related in any way to you, which we have transmitted to any company, or any public or private agency, or any person.

We may charge reasonable copying charges for this service, which are set forth in the statutes as well as a handling charge and actual postage.

We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.

**Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail (not available), you may request a paper copy of this notice at any time.

**Our duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy term the change will apply for all of your health information in our files.

**Re-disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

**Your right to complain**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

The U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

If you would like further information about our privacy policies and practices please contact:

Abshire Chiropractic Sports Center, L.L.C.  
913 South College Road, Suite 105  
Lafayette, Louisiana, 70503  
337-261-0100

This notice is effective as of \_\_\_\_\_. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal representative printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.

PATIENT: \_\_\_\_\_

EXAM DATE: \_\_\_\_\_



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### PATIENT INFORMATION

Address \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Single  Married  Widowed  Divorced

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_

Best time & place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I ( or my dependant ) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Jason Abshire all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
RELATIONSHIP DATE

### ACCIDENT INFORMATION

Is condition due to an accident?  No  Yes Date \_\_\_\_\_

Type of accident:  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Workers Comp.  Other

Attorney Name (if applicable): \_\_\_\_\_

### PATIENT CONDITION

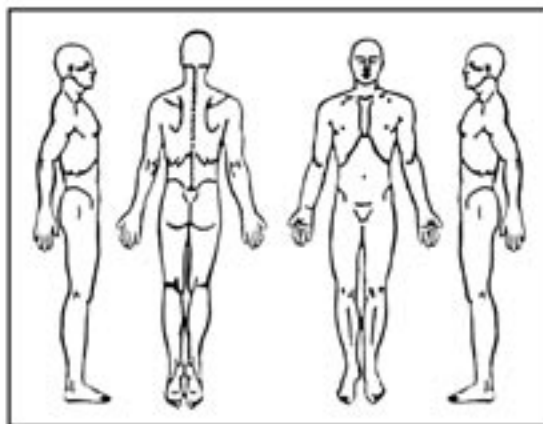
Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?

Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 to 10:

Least Severe 1 2 3 4 5 6 7 8 9 10 Most Severe

Type of pain:

- Sharp  Numbness  Burning  Stiffness
- Dull  Aching  Tingling  Swelling
- Throbbing  Shooting  Cramps  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:

- Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

- Sitting  Standing  Walking  Bending
- Lying Down

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other

Name and address of other doctors(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

**Indicate if you have had any of the following:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Measles              | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Migraine Headaches   | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Miscarriage          | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gout             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tumors, Growths    |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> Polio                | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Prostate Problem     | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis           | Other _____                                 |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Psychiatric Care     | _____                                       |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Rheumatoid Arthritis | _____                                       |

Are you pregnant Yes No Expected Date of Delivery: \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Medicines	_____	_____
Allergies	_____	_____

**INFORMED CONSENT TO CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical techniques, on me (or on the patient named below, for whom I am legally responsible) by a doctor of chiropractic named above.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that in no way are the above doctor(s) promising guaranteed results. I also understand that at any time, I have the right to refuse total or partial treatment.

By my (patient's or legal guardian's) signature I acknowledge that I understand the risks of chiropractic treatment and I choose to allow the doctor(s) associated with Abshire Chiropractic Sports Center, L.L.C. to treat me, or the person for whom I am responsible.

\_\_\_\_\_  
 Patient's name (please print)

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Signature of Parent/Guardian(if patient is a minor)

\_\_\_\_\_  
 Signature of Witness

## Notice of Financial Responsibility

The policy of Abshire Chiropractic Sports Center, L.L.C. regarding **Payment on an Account** is:

### *Office Visits:*

- One of the following payments is expected at the time services are rendered:
  - *Co-pay*
  - *\$200.00 for a new patient and \$60.00 for an established patient at time of service if deductible has not been met*
  - **Medicare Patients**
    - *Medicare patients are responsible for \$120.00 at time of service for the initial visit and \$40.00 at time of service for each follow-up visit.*

- *Insurance will be filed for the patient and **the balance on the account after the insurance processes the claim will be the patients responsibility.***

(Your insurance contract is an agreement between you and the insurance company, and as the subscriber, you are responsible for the terms of that agreement. Abshire Chiropractic Sports Center is a provider for many insurance companies. You may have coverage with an insurance company in which we are a provider but within the terms of your policy there may be a deductible and/or co-pay, which are your responsibility.)

- › The amount collected at the time of service is **NOT** the total charges for the visit. An itemized receipt will be given to the patient upon request.

- *Cash Accounts – payment is due at time service is rendered*

For the convenience of our patients, we accept Visa, MasterCard, and Discover, personal checks (\$25.00 charge for NSF checks).

Cash patients will receive a 30% discount of the total balance at the time of service

I have read the financial notice of Abshire Chiropractic Sports Center, L.L.C. and fully understand my responsibility.

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Signature

Date

(\* Upon request, the patient will receive a copy of this document.)