

### Auto Accident Questionnaire

1. What was the date of the accident? \_\_\_\_\_
2. What time did the accident occur? \_\_\_\_\_
3. How many vehicles were involved in the accident? \_\_\_\_\_
4. What was the estimated damage to the vehicle you were in? \_\_\_\_\_
5. What state did the accident occur in? \_\_\_\_\_
6. What city did the accident occur in? \_\_\_\_\_
7. What street or intersection were you on when the accident occurred?  
\_\_\_\_\_
8. What direction were you traveling in? \_\_\_\_\_
9. What type of impact was the auto accident? \_\_\_\_\_
10. Did your vehicle hit anything after the accident? if yes, please describe  
\_\_\_\_\_
11. Where were you sitting in the vehicle during the accident?  
\_\_\_\_\_
12. Did you know the accident was coming? \_\_\_\_\_
13. What type of vehicle were you in? \_\_\_\_\_
14. What type of vehicle impacted yours? \_\_\_\_\_
15. At the time of the impact, how fast was your vehicle moving? \_\_\_\_\_
16. At the time of impact, how fast was the other vehicle moving? \_\_\_\_\_
17. During and after the crash what happened to your vehicle? (circle all that apply)
  - kept going straight
  - kept going straight hitting a car in front
  - was hit by another vehicle
  - spun around
  - spun around and hit a stationary object
  - hit a stationary object
18. Did you lose consciousness during the accident? -yes                      - no
19. How was your head positioned during the accident? \_\_\_\_\_
20. How was your torso positioned during the accident? \_\_\_\_\_
21. How were your hands positioned during the accident? \_\_\_\_\_
22. Did your head hit anything during the accident? -no   - yes, please describe \_\_\_\_\_
23. Did your face hit anything during the accident? -no   - yes, please describe \_\_\_\_\_
24. Did your shoulders hit anything during the accident? -no   - yes, please describe \_\_\_\_\_

25. Did your neck hit anything during the accident? -no - yes, please describe \_\_\_\_\_
26. Did your chest hit anything during the accident? -no - yes, please describe \_\_\_\_\_
27. Did your hips hit anything during the accident? -no - yes, please describe \_\_\_\_\_
28. Did your knees hit anything during the accident? -no - yes, please describe \_\_\_\_\_
29. Did your feet hit anything during the accident? -no - yes, please describe \_\_\_\_\_
30. What kind of headrest was in your vehicle?  
 - movable fixed headrest  
 - non-movable fixed headrest  
 - no headrest
31. Where was the headrest positioned on your head? \_\_\_\_\_
32. Did you have your seat belt on during the accident? - yes -no
33. Did you slide out of your seat belt during the accident? \_\_\_\_\_
34. What was damaged in your vehicle? (Circle all that apply)  
 - windshield - rear bumper - mirror  
 - steering wheel - front bumper - knee bolster  
 - dashboard - trunk - back right door  
 - seat frame - front left door - completely totaled  
 - side window - front right door  
 - rear window - back left door
35. Choose the items that dented inward  
 - floorboards - side door - dashboard
36. Choose the doors that would not open as a result of the accident  
 - front left - front right  
 - rear left - rear right
37. Did you go to the hospital? If no, why and do not answer 38-43  
 \_\_\_\_\_
38. How did get to the hospital? \_\_\_\_\_
39. What was the name of the hospital? \_\_\_\_\_
40. Were you hospitalized over night? \_\_\_\_\_
41. Circle what you were prescribed at the hospital  
 - pain medication - muscle relaxers - neck brace
42. Did you receive any stitches for any cuts at the hospital? \_\_\_\_\_
43. Were x rays taken at the hospital? If yes, which area was taken? \_\_\_\_\_

**Walters Chiropractic PC**  
121 West King Street  
East Berlin PA 17316  
717-259-8056

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

**Sex:** Male / Female                      **Status:** Single / Married / Other \_\_\_\_\_

**Ethnicity:** Hispanic or Latino / Not Hispanic or Latino

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email Address \_\_\_\_\_  
\_\_\_\_\_

Employer Name \_\_\_\_\_

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

Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Insured Birth date \_\_\_\_\_

**Smoking Status:** Daily Smoker / Smokes some days / Former Smoker / Never Smoked

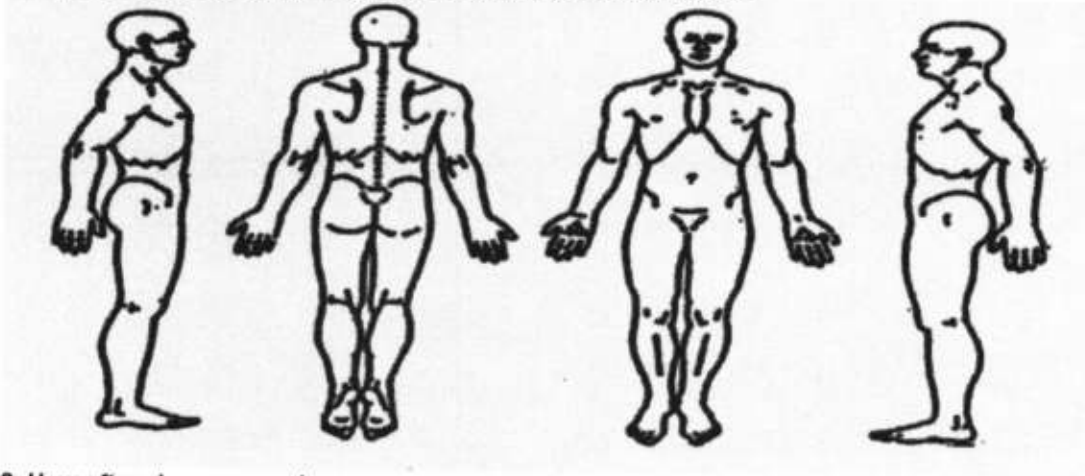
Have you had the Flu shot this season? When? \_\_\_\_\_

Any allergies to medications? Please List & Indicate Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. Who else have you seen for your problem?

- Chiropractor. Date of Last visit? \_\_\_\_\_  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?  
\_\_\_\_\_

12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem? \_\_\_\_\_

13b. What relieves your problem?  
\_\_\_\_\_

14. What concerns you the most about your problem; what does it prevent you from doing?  
\_\_\_\_\_

15. How would you rate your overall Health?

- Excellent  Very Good  Good  Fair  Poor

**16. What type of exercise do you do?**

- Strenuous     Moderate     Light     None

**17. Family History (indicate Mother, Father, Brother, Sister, etc):**

Rheumatoid Arthritis \_\_\_\_\_ Diabetes \_\_\_\_\_ Lupus \_\_\_\_\_  
Heart Problems \_\_\_\_\_ Cancer \_\_\_\_\_ ALS \_\_\_\_\_

**18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present	
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst	
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use	
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence	
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies	
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression	
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash	
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<b>For Females Only</b>		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite			<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain			<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer			<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination			
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances			
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness			
<input type="checkbox"/>	<input type="checkbox"/> Other: _____					

**19. List all prescription medications you are currently taking:**

\_\_\_\_\_  
\_\_\_\_\_

**20. List all of the over-the-counter medications you are currently taking:**

\_\_\_\_\_

**21. List all surgical procedures and hospital admissions you have had:**

\_\_\_\_\_

**22. What activities do you do at work?**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Sit:                  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day       | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:                | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day       | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work:        | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day       | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Driving vehicle:      | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Performs Manual Labor | <input type="checkbox"/> Reads a lot     | <input type="checkbox"/> Travels frequently |  |

**23. What activities do you do outside of work?**

\_\_\_\_\_

**24. Have you ever been to a chiropractor?**     No     Yes    If yes, how long ago? \_\_\_\_\_

**25. Have you had an Xray or Mri of the spine in the past two years? LIST BODY PART AND MEDICAL CENTER WHERE IMAGE WAS TAKEN** \_\_\_\_\_

**26. Have you had significant past trauma?**     No     Yes explain \_\_\_\_\_

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

### SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self -care.
- I do not get dressed. I wash with difficulty and stay in bed.

### SECTION 3 - LIFTING

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### SECTION 4 - WORK

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 5 - HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

### SECTION 6 - CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

### SECTION 7 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

### SECTION 8 - DRIVING

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

### SECTION 9 - READING

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

### SECTION 10 - RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

SCORE \_\_\_\_\_ [50]

% score = \_\_\_\_\_



Name: \_\_\_\_\_ Date \_\_\_\_\_

### The Revised Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE THAT MOST APPLIES TO YOU TODAY.

#### Section 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

#### Section 2 – Personal Care (washing, dressing, etc.)

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

#### Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

#### Section 4 – Walking

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

#### Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

#### Section 6 – Standing

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

#### Section 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

#### Section 8 – Social life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life, and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

#### Section 9 – Travel

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to see alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

#### Section 10 – Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

OFFICE USE: Score \_\_\_\_\_ %Disability

WALTERS CHIROPRACTIC PC  
121 West King St  
East Berlin, PA 17316

**ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

**Assignment of Benefits/Financial Responsibility**

The undersigned hereby authorizes Dr. Shannon Walters to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment if any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

**Designation of Authorized Representative**

The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974(ERISA) as provided in 29 CFR 2560-503-1(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents, claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

**Authorization for Release of Information**

The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment. The undersigned hereby authorizes my Employer to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

**Revocation and Acknowledgement**

A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefits claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to this Provider; however, the undersigned understands that all actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

**Important Information for our Patients Regarding Exams and Re-Exams**

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal law and the American Medical Association. These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules and of uncovered services.

Examples of services not covered may include, but not limited to:

**Examinations and Re-Examination:** Both of which are periodically necessary to justify the medical necessity of your chiropractic care.

**Spinal Manipulation**

**Physical Medicine:** such as ultrasound, muscle stimulation and massage therapy.

**Supplies:** such as pillows, biofreeze, orthotics, supports, supplements, oils etc.

**Our Doctor cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment from your Insurance Company!**

While we regret that your Insurance carrier may not pay for more Exams and Re Exams, it is required to prove medical necessity of all care performed in our office. If at any time your Insurance Company denies payment, you will be responsible for the payment due.

Our able, experienced business office staff will be happy to assist you with any questions. Providing you with high quality healthcare remains our first priority. We thank you for choosing us to assist you with your healthcare needs.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Permission to Release Medical Information to Another Individual**

On occasion, we have had family members call regarding appointments, account balances, status of treatment plan, etc. According to the Health Information Portability and Accountability Act (HIPAA), we are unable to release any protected health information to anyone without a written authorization. **THIS AUTHORIZATION IS VALID UNTIL A NEW RELEASE FORM IS COMPLETED**

If you wish to authorize a person to receive any medical information on your behalf, please complete the form below.

**Print Patient's Full Name** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Effective Date of Authorization** (today's date): \_\_\_\_\_

At my request, I give Walters Chiropractic permission to release and discuss protected health information with the following person(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I give Walters Chiropractic entities permission to leave any protected health information on an answering machine or voicemail.

YES                      NO

**ACKNOWLEDGMENT OF OUR HIPAA PRIVACY PRACTICES AND CONSENT TO CHIROPRACTIC SERVICES.**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Walters Chiropractic Notice of Privacy Practices for protected health information.

I hereby request and consent to the performance of chiropractic adjustments, physical medicine, and exercises. I understand the practice of chiropractic carries some risks to treatment, including, but not limited to: fractures, disc injury, stroke, dislocations, and sprains. Further, I wish to rely on Dr. Walters to exercise judgment during the course of the procedures which she feels are in my best interest at the time, based upon the facts that are known. My treatment in this office may include any of the above mentioned treatments. Though chiropractic treatment is usually beneficial, I understand and have been informed that it is not an exact science and no guarantee has been made to me. I have had the opportunity to discuss with the doctor and/or staff the benefits of an adjustment and other treatment performed in the office. I have had the opportunity to ask questions about my concerns and authorize treatment.

**Print Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

# HIPAA Notice of Privacy Practices

WALTERS CHIROPRACTIC PC  
121 WEST KING STREET/735 HARRISBURG PIKE  
EAST BERLIN PA 17316/DILLSBURG PA 17019  
717-259-8056/717-432-7780

**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.**

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Revised: 12/7/17

## USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

**Other Permitted and Required Uses and Disclosures** will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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HIPAA COMPLIANCE OFFICER

MELISA BUSBEY

Phone

717-259-8056

email

walterschiro@wchiro.comcastbiz.net

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form.

Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.