Dr. Stacy Clark, D.C.
6 Ebco Circle
Waynesboro, VA 22980
Phone: (540) 946-2311 Fax: (540) 946-2312

PATIENT DATA SHEET

General Information

First Name _____
Middle Initial _____
Last Name _____
Suffix _____
Called Name _____
Address _____
City _____
_____
Zip Code _____

Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Marital Status Single Married Other _____
Birthdate _____
Sex Male Female
Referred by _____

For Office Use Only
Account Number _____
Account Category _____
Account Type 1 2 3 4 5 6 7 8 9 Z

Appointment Reminder: Do you prefer (choose one) text: ____ voicemail: ____ none: ____

Emergency Contact Person: _____ Phone: _____

May our office staff leave messages concerning your personal health information on your voicemail?
____yes ____no

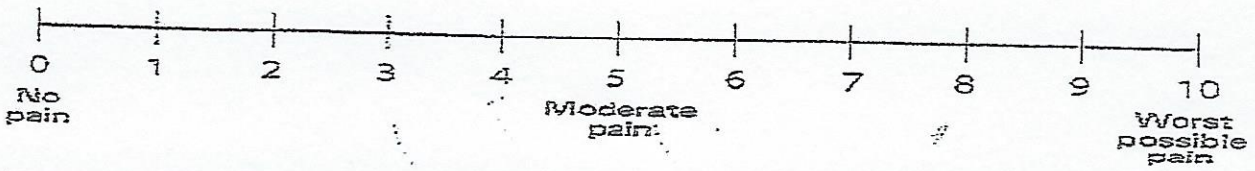
If yes, which number would you prefer us to use? _____

Patient Signature: _____ Date: _____

Dr. Stacy Clark, D.C.
The Virginia Chiropractic and Natural Health Center
6 Ebco Circle
Waynesboro, VA 22980
Phone: (540) 946-2311 Fax: (540) 946-2312

Patient Name: _____ Date: _____

0-10 Numeric Pain Intensity Scale *



Please list number that most accurately matches your pain level for each location. (Be specific)

Neck Pain: _____ Mid Back Pain: _____ Low Back Pain: _____

Please answer the following questions:

Do you have any new injuries? Yes: _____ No: _____

If yes, please describe:

_____

_____

What activities make the pain worse?

_____

_____

What activities make the pain better?

_____

_____

_____ _____

Patient Signature Date

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NEW PATIENT INFORMATION

Full Name: _____ Date: _____

Are you present problems due to an injury? ☐ Yes ☐ No Enter the date of injury: _____

Was the Injury? ☐ Job Related ☐ Auto Accident ☐ Other: _____

Briefly describe the accident or injury:

_____

_____

Do you have any current work restrictions due to this condition?

Off Work: ☐ Yes ☐ No ☐ Previously From: _____ To: _____
Light Duty: ☐ Yes ☐ No ☐ Previously From: _____ To: _____

What type of work do you do?

_____

Do you suffer from any condition other than that for which you are consulting us? Yes ☐ No ☐

_____

HABITS:

☐ Current Every Day Smoker ☐ Current Some Day Smoker

☐ Former Smoker ☐ Never Smoker

Exercise: ☐ None ☐ Moderate ☐ Daily

Family History:

	Diabetes	Cancer	Back Pain	Other
Mother				
Father				
Siblings				

Are you taking any medication (prescription or over-the-counter)? ☐ Yes ☐ No
If Yes, please indicate the following:

Medication: _____ Medication: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____

Do you have allergies to any medication? ☐ Yes ☐ No
If Yes, please indicate the following:
Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____

Have you ever had any surgeries? ☐ Yes ☐ No
If Yes, please indicate the following:
Surgery Type: _____ Date of Surgery: _____
Surgery Type: _____ Date of Surgery: _____
Surgery Type: _____ Date of Surgery: _____
Surgery Type: _____ Date of Surgery: _____

Have you ever had X-rays taken? ☐ Yes ☐ No
If Yes, when? _____ By Whom? _____
What area of the body were these X-rays taken? _____

HEALTH HISTORY

Please check the box for each current or past symptom listed:

General Symptoms:

				Muscles & Joints:			
Bronchitis		Loss of Sleep		Backache		Swollen Joints	
Chills		Loss of Weight		Foot Trouble		Tremors	
Convulsions		Nervousness		Hernia			
Dizziness		Night Sweats		Pain between Shoulders			
Fainting		Numbness or Pain in Arms/Legs/Hands		Painful Tailbone			
Fatigue		Wheezing		Stiff Neck			
Headache				Spinal Curvature			

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

Alcoholism		Cancer		Goiter	Measles		Polio	
Anemia		Chicken Pox		Heart Disease	Mumps		Rheumatic Fever	
Appendicitis		Eczema		HIV Positive	Pleurisy		Tuberculosis	
Arthritis		Epilepsy		Influenza	Pneumonia		Venereal Disease	

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

_____ _____
Patient's/Guardian's Signature Date

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NO-SHOW APPOINTMENT FEE

There will be a **$50.00 "no-show" fee** for any appointment not cancelled 24 hours in advance.

We are very excited that we are now able to offer reminder calls as a courtesy to our patients. However, it is still your responsibility to keep up with your appointments. We kindly ask that you provide us the courtesy of a **24 hour notice** if you are unable to keep your appointment. This allows us the opportunity to offer that time slot to another patient that is in need of care.

Thank you!

As the undersigned, I acknowledge and understand that it is my responsibility to keep up with my appointments and that I will be charged a **$50.00 fee** in the event that I do not keep my appointment and I do not give proper notice of my cancellation.

_____ _____

Patient's Name – Print Today's Date

_____

Patient's Name - Signature

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INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are correct and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc or vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____

_____ _____

Signature Date

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FINANCIAL OFFICE POLICY

MEDICARE PATIENTS

We accept assignment from Medicare and we will submit your claims for you. The check is usually sent directly to our office. The ONLY services that Medicare will cover when provided by a Chiropractor is manual manipulation of the spine. Maintenance and preventative care is NOT covered. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are considered NON-COVERED. These services include, but are not limited to: x-rays, examinations, therapies, acupuncture, gua sha, and massage therapy. Medicare patients are fully responsible for charges of any non-covered services at the time service is rendered. Secondary insurance may or may not pay for non-covered services. Please see IN-NETWORK GROUP OR INDIVIDUAL INSURANCE for payment policy.

PATIENTS WITH OUT-OF-NETWORK INSURANCE

If you have insurance coverage with a company that we are not currently in-network with, insurance claims will not be submitted by our office. However, as a courtesy to you, our office will give you a printout with all the necessary information for you to submit to your insurance company for reimbursement. Payment in full will be expected at the time services are rendered as your account will be considered a self-pay cash account. For more details please see "Cash Paying Patients".

IN-NETWORK GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. As a patient, it is your responsibility to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify your benefits; however, the benefit quote obtained from your insurance company is not a guarantee of payment. As a courtesy to you, our office will complete and submit the necessary insurance forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, co-insurance or co-pays. Your portion of the charges is due at the time the services are rendered. You will be billed for any remaining balance due after insurance reimbursement.

CASH PAYING PATIENTS

If you do not fall under any of the other categories of payment, you are a CASH patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT CARD. We do not carry patient balances. There is a $25.00 return check fee for any check that is returned as "insufficient funds".

I have read and understand the payment policy of The VA Chiropractic Center. I understand that my insurance is an arrangement between myself and my insurance company, NOT between The VA Chiropractor Center and my insurance company. I request that The VA Chiropractic Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 90 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Stacy Clark that fees will be due and payable immediately.

_____ _____

Patient's Signature (or guardian if patient is a minor) Date

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

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NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we 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 PHI. "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

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made only with your consent, authorization or opportunity to object unless required by law. 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 HEALTH INFORMATION RIGHTS

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

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical

information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

Summary of Rights and Obligations Concerning Health Information

[name of practice] is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law, as well as by ethics of the medical profession. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by [name of practice]. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have certain rights to your health information. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices*. In the following pages, we explain our privacy practices and your rights to your health information in more detail. If you have limited proficiency in English, you may request a Notice of Privacy Practices in [name of language(s)]. **[Note: Although not required by the HIPAA Privacy Rule, federal law requires a provider to make material distributed to the public, such as a Notice of Privacy Practices, available in the languages of persons with limited English proficiency in the provider's service area.]**

Business Associates. [Name of provider] sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

The following paragraph is required only if the practice intends to use appointment reminders.

Appointment Reminders. We may use and disclose information in your medical record to contact you as a reminder that you have an appointment at [name of provider]. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

Treatment Options. We may use and disclose your health information in order to inform you of alternative treatments.

Release to Family/Friends. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Health-Related Benefits and Services. **The following sentence is required only if the practice intends to send information to patients concerning health-related benefits or services.** We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest you.

Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement. We may release your health information:

- in response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
- to identify or locate a suspect, fugitive, material witness, or similar person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at [name of provider];
- to coroners or medical examiners;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
- to authorized federal officials for intelligence, counterintelligence, and other
- national security authorized by law; and
- to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

De-identified Information. We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

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 protect health information. We are also 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.