

Accents on Health
Chiropractic*Acupuncture*Massage
5950 S. Willow Dr, Suite 205
Greenwood Village, CO 80111



PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ SSN _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____/____/____ Sex M F Email Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Do you prefer to receive calls at Home Work Cell No Preference?
 Married Widowed Single Minor Divorced Separated Partnered
Name of Spouse/Partner /Parent _____ Number of Children _____
Patients Employer/School _____ Occupation _____
Have you seen a Chiropractor/Acupuncturist before? Who _____
Approximate Last Visit _____ Reason for that Visit _____
Is your condition related to Employment Y N; Auto Accident Y N
If yes, State in which the accident or injury occurred. _____
Who can we thank for referring you to Accents on Health? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work Phone _____

INSURANCE INFORMATION

Name of the Insured First _____ Middle Initial _____ Last _____
Patient Relationship to the Insured Self Spouse Child Other (Please specify) _____
Address of the Insured (if different from above) _____ City, _____ State _____ Zip _____
Employer of the Insured _____
Date of Birth of Insured _____ SSN _____ - _____ - _____ Sex of the Insured M F
Phone Numbers of the insured. Home _____ Work _____ Cell _____
Insurance Company _____ Phone _____ Group# _____ Employer# _____
Insurance Company address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual benefit? _____

Do you have additional insurance Yes No If yes, please complete the following

Name of the Insured First _____ Middle Initial _____ Last _____
Patient Relationship to the Insured Self Spouse Child Other (Please specify) _____
Address of the Insured (if different from above) _____ City, _____ State _____ Zip _____
Employer of the Insured _____
Date of Birth of Insured _____ SSN _____ - _____ - _____ Sex of the Insured M F
Phone Numbers of the insured. Home _____ Work _____ Cell _____
Insurance Company _____ Phone _____ Group# _____ Employer# _____
Insurance Company address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual benefit? _____

ASSIGNMENT OF BENEFITS

You are instructed to pay directly to Dr. Lea Yoder, tax ID #65-0439977, for all Professional services rendered.
This instruction to you is an assignment of the rights under medical coverage to the extent of this bill.

Signature _____ Date _____

- Please note that we do offer a discount program for Senior's. Please ask if you are interested

Patient Basic Information

CURRENT HEALTH CONDITION(S)

List you current health complaints in order of priority:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

When did this condition begin? _____ Has this condition occurred before? Yes No

If yes, please explain _____

What seems to make it feel better

- Bending back Bending forward Bending Left Bending Right Twisting Left Standing Twisting Right Sitting
 Lifting Lying down Bed Rest Ice Heat Massage Medication Chiropractic Acupuncture Better in A.M.
Better in P.M.
Other _____

What seems to make it feel worse

- Bending back Bending forward Bending Left Bending Right Twisting Left Coughing Twisting Right
 Sneezing Straining Standing Sitting Lifting Lying down Worse in A.M. Worse in P.M.
 Other _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem _____

What is the primary goal you would like to achieve today? _____

What is your overall goal for getting better? _____

Have you had X-rays taken in the last six months? No Yes If yes, where _____

PAST HEALTH HISTORY (Please check or describe)

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
Broken Bones _____ Other _____

Major Accidents or Falls: _____

Hospitalizations (other than above): _____

Are you currently taking medication Yes No

If yes please list Medication and what it was prescribed for

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you currently taking Vitamins or Herbs Yes No

If yes please list for

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please describe the foods you eat in a typical day

Breakfast:

Lunch:

Dinner:

Snacks:

How would you describe the state of your immune system?

Excellent Good Fair Poor

Are you under unusual stress right now Yes No

NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration/</i></p> <p>A I can concentrate fully when I want to with no difficulty. B I can concentrate fully when I want to with slight difficulty. C I have a fair degree of difficulty in concentrating when I want to. D I have a lot of difficulty in concentrating when I want to. E I have a great deal of difficulty in concentrating when I want to. F I cannot concentrate at all.</p>
<p><i>SECTION 2 - Personal Care (Washing, Dressing, etc.)</i></p> <p>A I can look after myself normally without causing extra pain. B I can look after myself normally, but it causes extra pain. C It is painful to look after myself and I am slow and careful. D I need some help, but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p>A I can do as much work as I want to. B I can only do my usual work, but no more. C I can do most of my usual work, but no more. D I cannot do my usual work. E I can hardly do any work at all. F I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain. B I can lift heavy weights, but it gives extra pain. C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can lift very light weights. F I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p>A I can drive my car without any neck pain. B I can drive my car as long as I want with slight pain in my neck. C I can drive my car as long as I want with moderate pain in my neck. D I cannot drive my car as long as I want because of moderate pain in my neck. E I can hardly drive at all because of severe pain in my neck. F I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A I can read as much as I want to with no pain in my neck. B I can read as much as I want to with slight pain in my neck. C I can read as much as I want to with moderate pain in my neck. D I cannot read as much as I want because of moderate pain in my neck. E I cannot read as much as I want because of severe pain in my neck. F I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>A I have no trouble sleeping. B My sleep is slightly disturbed (less than 1 hour sleepless). C My sleep is mildly disturbed (1-2 hours sleepless). D My sleep is moderately disturbed (2-3 hours sleepless). E My sleep is greatly disturbed (3-5 hours sleepless). F My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>A I have no headaches at all. B I have slight headaches which come infrequently. C I have moderate headaches which come infrequently. D I have moderate headaches which come frequently. E I have severe headaches which come frequently. F I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>A I am able to engage in all of my recreational activities with no neck pain at all. B I am able to engage in all of my recreational activities with some pain in my neck. C I am able to engage in most, but not all of my recreational activities because of pain in my neck. D I am able to engage in a few of my recreational activities because of pain in my neck. E I can hardly do any recreational activities because of pain in my neck. F I cannot do any recreational activities at all.</p>

COMMENTS: _____

Name _____ Age _____ Date _____ Score _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: 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 circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 - Pain Intensity</p> <p>A The pain comes and goes and is very mild. B The pain is mild and does not vary much. C The pain comes and goes and is moderate. D The pain is moderate and does not vary much. E The pain comes and goes and is severe. F The pain is severe and does not vary much.</p>	<p>SECTION 6 - Standing</p> <p>A I can stand as long as I want without pain. B I have some pain while standing, but it does not increase with time. C I cannot stand for longer than one hour without increasing pain. D I cannot stand for longer than 1/2 hour without increasing pain. E I cannot stand for longer than ten minute without increasing pain. F I avoid standing, because it increases the pain straight away.</p>
<p>SECTION 2 - Personal Care</p> <p>A I would not have to change my way of washing or dressing in order to avoid pain. B I do not normally change my way of washing or dressing even though it causes some pain. C Washing and dressing increases the pain, but I manage not to change my way of doing it. D Washing and dressing increases the pain and I find it necessary to change my way of doing it. E Because of the pain, I am unable to do some washing and dressing without help. F Because of the pain, I am unable to do any washing or dressing without help.</p>	<p>SECTION 7 - Sleeping</p> <p>A I get no pain in bed. B I get pain in bed, but it does not prevent me from sleeping well. C Because of pain, my normal night's sleep is reduced by less than one than one quarter. D Because of pain, my normal night's sleep is reduced by less than one-half. E Because of pain, my normal night's sleep is reduced by less than three-quarters. F Pain prevents me from sleeping at all.</p>
<p>SECTION 3 - Lifting</p> <p>A I can lift heavy weights without extra pain. B I can lift heavy weights, but it causes extra pain. C Pain prevents me from lifting heavy weights off the floor. D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table. E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F I can only lift very light weights, at the most.</p>	<p>SECTION 8 - Social Life</p> <p>A My social life is normal and gives me no pain. B My social life is normal, but increases the degree of my pain. C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc. D Pain has restricted my social life and I do not go out very often. E Pain has restricted my social life to my home. F I have hardly any social life because of the pain.</p>
<p>SECTION 4 - Walking</p> <p>A Pain does not prevent me from walking any distance. B Pain prevents me from walking more than one mile. C Pain prevents me from walking more than 1/2 mile. D Pain prevents me from walking more than 1/4 mile. E I can only walk while using a cane or on crutches. F I am in bed most of the time and have to crawl to the toilet.</p>	<p>SECTION 9 - Traveling</p> <p>A I get no pain while traveling. B I get some pain while traveling, but none of my usual forms of travel make it any worse. C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. D I get extra pain while traveling which compels me to seek alternative forms of travel. E Pain restricts all forms of travel. F Pain prevents all forms of travel except that done lying down.</p>
<p>SECTION 5 - Sitting</p> <p>A I can sit in any chair as long as I like without pain. B I can only sit in my favorite chair as long as I like. C Pain prevents me from sitting more than one hour. D Pain prevents me from sitting more than 1/2 hour. E Pain prevents me from sitting more than ten minutes. F Pain prevents me from sitting at all.</p>	<p>SECTION 10 - Changing Degree of Pain</p> <p>A My pain is rapidly getting better. B My pain fluctuates, but overall is definitely getting better. C My pain seems to be getting better, but improvement is slow at present. D My pain is neither getting better nor worse. E My pain is gradually worsening. F My pain is rapidly worsening.</p>

COMMENTS: _____

NAME: _____ **DATE:** _____ **SCORE:** _____

STANDARD FORM: Primary complaint - Please circle: Low back / leg OR Neck / arm

NAME _____ DATE _____ BD _____ SC _____

1. Where do you have pain? Place a 4 for all appropriate sites. (2x)
 neck shoulders upper back lower back leg

2. How long ago did your **current** episode begin? (2x)
1. **Less than two weeks ago** 2. **2 weeks to <8 weeks ago**
3. **8 weeks to < 3 months ago** 4. **Three months to < six months ago**
5. **>6 months ago**

3. How many **previous episodes** required treatment? (2x)
 None **1** **2** **3** **4 or more**

4. Have you been hospitalized or had surgery for the same or similar complaint before? **Yes / No**

5. Please indicate your usual level of pain during **the past week**:
No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst possible pain**

6. How **often** would you say that you have experienced pain episodes, on average during **the past 3 months**?
(Circle one number)
Never 0 1 2 3 4 5 6 7 8 9 10 **Always**

7. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?
None of the time 0 1 2 3 4 5 6 7 8 9 10 **All of the time**

8. During the last week, how often have you taken medication (such as aspirin, Motrin, Tylenol or prescription medication) for your pain complaint?
Not at all 0 1 2 3 4 5 6 7 8 9 10 **3 or more times a day**

9. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
Delighted 0 1 2 3 4 5 6 7 8 9 10 **Terrible**

10. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week**:
Not at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely anxious**

11. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week**:
I can reduce it 0 1 2 3 4 5 6 7 8 9 10 **I can't reduce it at all**

12. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely depressed**

13. How would you **rate your general health?** (10-X)

Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

14. Do you **smoke** tobacco a pack a day or more? **Yes / No**

15. An increase in pain is an indication that I should stop what I am doing until the pain decreases. (10-X)

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

16. Physical activity makes my pain worse?

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

17. I can do light work for an hour? (10-X)

Can't do it because of pain problem 0 1 2 3 4 5 6 7 8 9 10 **Can do it without pain being a problem**

18. I can sleep at night (10-X)

Can't do it because of pain problem 0 1 2 3 4 5 6 7 8 9 10 **Can do it without pain being a problem**

19. How physically demanding is your job -include housework if not employed outside the home?

Not at all demanding 0 1 2 3 4 5 6 7 8 9 10 **Very Demanding**

20. Have you been disabled due to the same or similar pain/complaint in the last 12 months? **Y / N**

21. I should not do my normal work with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

If you are disabled from work, when did your disability start? **Date** _____

22. How well do you like your work? (10-x)

Not at all 0 1 2 3 4 5 6 7 8 9 10 **Very much**

23. What kind of trouble at work do you think you will have sitting or standing 6 weeks from now?

No trouble 0 1 2 3 4 5 6 7 8 9 10 **Extreme trouble**

24. On a scale of 0 to 10, how certain are you that you will be working in six months?

Very certain 0 1 2 3 4 5 6 7 8 9 10 **Not certain at all**

Please sign your name _____ **Date** _____

FUNCTIONAL ASSESSMENT SCREEN QUESTIONNAIRE

For each of the following tasks listed below, please check one column which best describes the case or else the degree of difficulty which you have in trying to perform each one. As a guideline:

- EASY:** No difficulty performing the task.
SOME: Some difficulty performing the task, but can still manage it well enough.
A LOT: The activity can still be done, but there is a lot of difficulty attempting it.
UNAB: Unable: Attempt to perform the task; however, it is too difficult to do.
NOT A: Not Applicable: Someone else in your household does this task
 or you choose not to do it.

	0	1	2	3	
ACTIVITY	EASY	SOME	A LOT	UNAB	NOT A
1. Cutting toe nails					
2. Getting up form a low seat					
3. Climbing stairs					
4. Washing windows or walls					
5. Doing grocery shopping					
6. Handling personal finances					
7. Playing favorite sports					
8. Carrying on a conversation					
9. Doing social activities with others					
10. Concentrating for at least 15 minutes					
11. Sitting for long periods					
12. Standing for long periods					
13. Reaching, grasping, pinching					
14. Driving an automobile					
15. Boarding and exiting from a bus					

Comments: _____

NAME _____ DATE _____ AGE _____

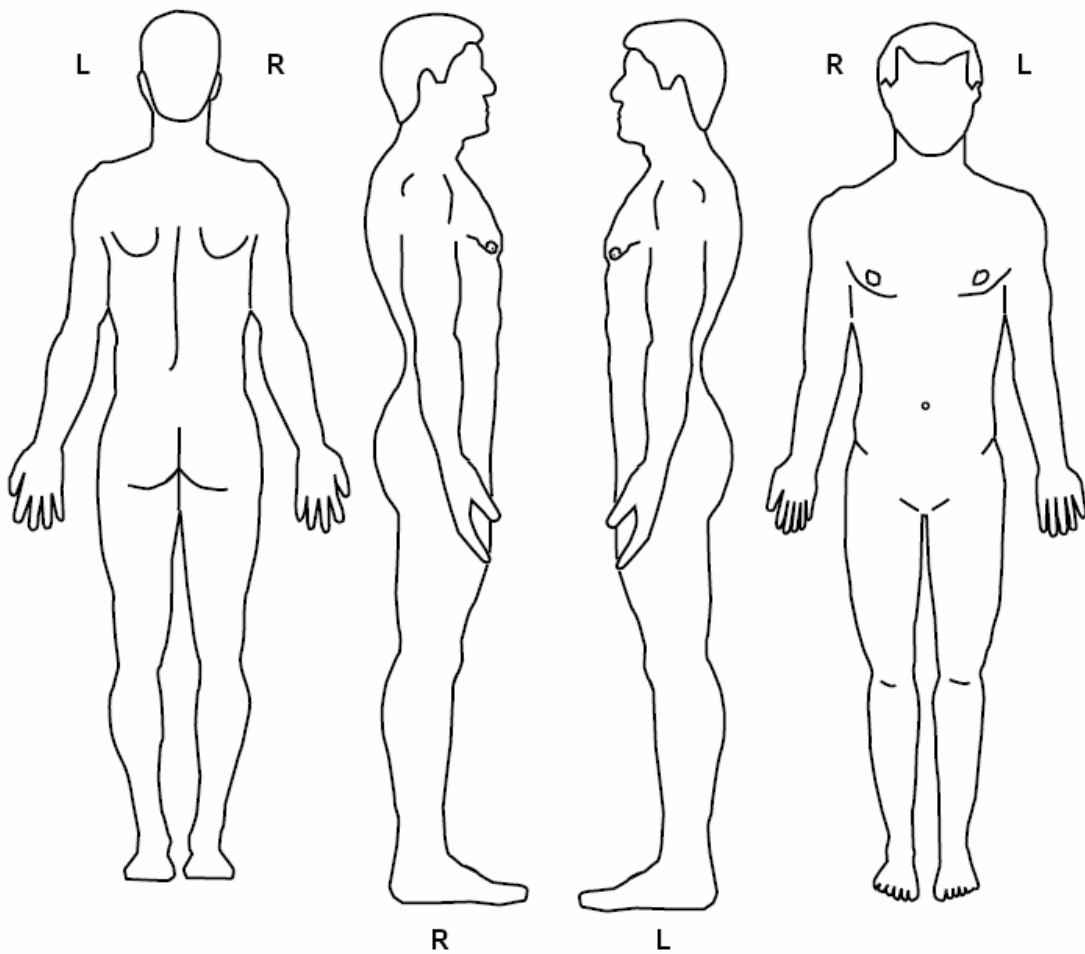
PAIN LOCATION, INTENSITY & FREQUENCY QUESTIONNAIRE

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----- Pins & Needles oooooo
----- Needles oooooo
Burning Pain xxxxxxxx
Stabbing Pain ///////////////
Aching Pain (((((((((

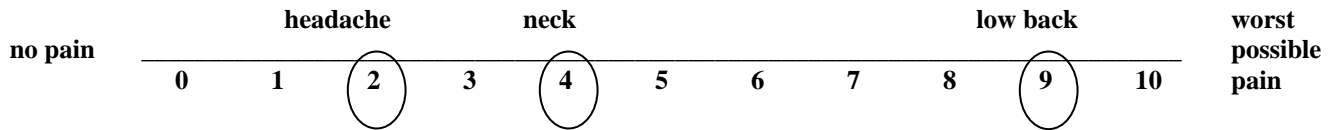


QUADRUPLE VISUAL ANALOGUE SCALE

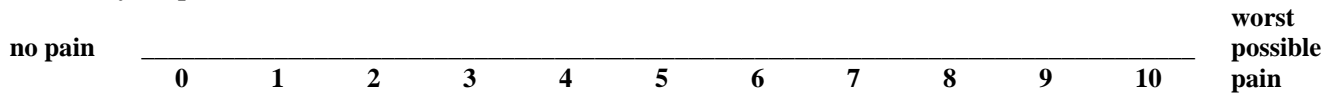
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

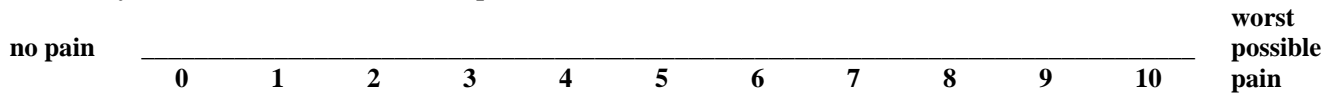
EXAMPLE:



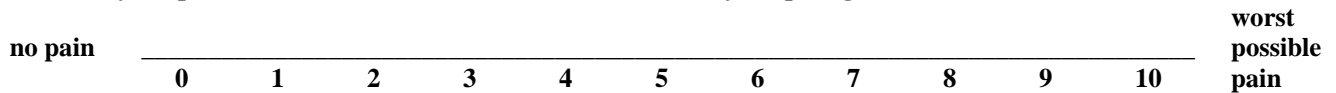
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

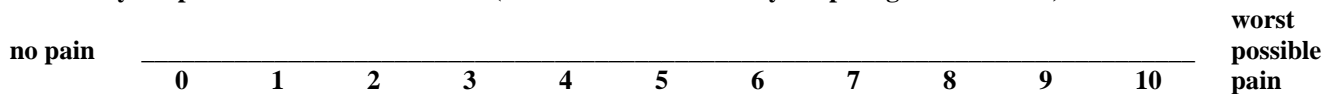


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

NAME _____ AGE _____ DATE _____

SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

J-5c. Review of systems (ROS)

Patient Financial Profile Health Insurance
OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will be pleased to accept your insurance assignment as soon as the responsible party verifies your exact coverage. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Office policy regarding insurance assignment:

1. Since by taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
2. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
3. We will bill your insurance on a 30-day cycle as long as you're receiving Chiropractic care in this office.
4. You are responsible to pay your deductibles and a percentage/ co-pay of your bill on each visit. You must also pay any amount not covered by your insurance policy (s). When this office receives a check from your insurance company, you will be informed of any amount due over and above the amount paid by your insurance company and the amount of money you have paid toward your bill. At the time you are informed of the amount due, you agree to pay the balance in full for that billing cycle. This office accepts cash, check and credit cards as payment.
5. You are required to sign an "Authorization, Assignment & Acknowledgement" form and any other assignment documents required by your insurance company on your first office visit.
6. Our office DOES NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied or reduced you are responsible for the full amount of your bill.
7. Our office WILL NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
8. All special arrangements regarding finances must be signed by the doctor and patient and / or other representative.

If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment when coverage is verified.

Print, Full Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____

Informed Consent To Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop,” such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed name

Signature

Date

HIPAA NOTICE of PRIVACY PRACTICES

Accents on Health

5950 S. Willow Drive, suite 205. Greenwood Village, CO 80111

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 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 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 or 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 our 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities. Employee review, activities, training of medical students, licensing, and conduction 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 eating 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.

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, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this 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:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and to provide individuals with, this notice of our legal duties and privacy practices with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our privacy Practices:

Print Name _____ Signature _____ Date _____

Insurance Verification Report

Dr. Lea Yoder

Patient Name: _____ Patient SSN: _____

Insured Name: _____ Insured ID #: _____

Insured's Employer _____ Group #: _____ DOB: _____

Insurance Cc: _____ Ins. Co. Phone #: _____

Claims Address: _____

Coverage (for Office Use)

Is this policy still in effect? _____ Effective Date: _____

Out of network chiropractic benefits? _____

Deductible? _____ Met? _____ Copay? _____

% Paid? _____ Max Visits or \$ amount? _____

Out of pocket expense? _____ % after? _____

Is a referral or pre-certification necessary? _____

of modalities per visit with an adjustment? _____

Does this policy cover acupuncture by a DC, certified licensed acupuncturist? _____

Are there any massage benefits? _____

Are Orthotics covered? _____

Verification

Spoke with? _____ Title? _____

Comments: _____

Verifying Signature: _____ Date: _____