Full Circle Chiropractic

Office Policies and Procedures

- Payment/Co-payment is due at the time of service rendered.
- Payment is accepted in the form of cash, credit card or personal check.
- Full Circle Chiropractic only accepts Excellus Blue Cross/Blue Shield insurance at this time, but we are more than willing to create a *superbill* for you to submit to your insurance for reimbursement if your plan reimburses for chiropractic care.
- If you need to cancel an appointment, please give as much notice as possible.
- If you are running late for an appointment, and can safely do so, please call or text to inform us.
- At Full Circle Chiropractic we are required to adhere to HIPPA laws. Therefore, if you desire any other person(s) to have access to your information, please make sure that you do this in writing by filling out the appropriate paperwork (part of your initial new-patient paperwork handouts) or an additional copy can be given to you at any time.
- Full Circle Chiropractic does not participate in Workers Compensation.
- Full Circle Chiropractic does not accept assignment (direct payment) from no fault. In these cases, payment is expected from the patient at time of services rendered. We will provide receipts and/or a statement for you to submit and are more than happy to fill out any paperwork required.

- If any documentation or forms are needed, please allow up to 3 days to fill the request.
- A signed copy of this form will be kept as a hard copy and electronically as part of your record.

  You may request a copy at any time.

I acknowledge that I have received, read and understand Full Circle Chiropractic's Office Policies and Procedures.

______________________________________ __________________

Signature Date

Full Circle Chiropractic

NOTICE OF PATIENT PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. This notice describes the practices of this facility, Full Circle Chiropractic, PLLC. For example:

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or your primary care physician. Your primary care physician may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the primary care physician's office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category if uses or disclosures, we will explain what we mean an try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways permitted to use and disclose information will fall within one of the categories.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose medical information about you to doctors, nurses, technicians, medical student, or other facility personnel who are involved in taking care of you at the facility. For example, a doctor treating you for an injury may need to know if you have diabetes because diabetes may slow the healing process. We may also disclose medical information about you to people outside the facility who may be involved in your medical care after you leave our facility.

Payment: We may use and disclose your health information so that the treatment and services you receive at the facility may be billed to, and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received at the facility so that your health plan will pay us or reimburse you for the treatment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Friends and Family:
We may disclose your medical information to a family member, or friend or other person to the extent necessary to help with your healthcare or payment for your healthcare. Before we disclose your medical information to a person involved with your healthcare or payment for your healthcare, we will provide you with an opportunity to object to such uses and disclosures. If you are not present, or in the event of your incapacitation or an emergency, we will disclose your medical information based on our professional judgement of whether the disclosure would be in your best interest.

Appointment Reminders:
We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives:
We may use and disclose medical information to tell you about, or recommend alternative treatments, therapies, healthcare providers or care settings that may be of interest to you or appropriate for your care.

Healthcare Providers and Services:
We may use and disclose medical information to tell you about facility-affiliated-healthcare providers and healthcare services that we provide that may be of interest to you.

Research:
Under certain circumstances we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one treatment to those who received another for the same condition.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities per requirement of federal, state or local law.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

To Avert a Serious Threat to Health or Safety:
We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure however would only be to someone able to help prevent the threat.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders
(Such as voicemail messages, postcards, or letters).

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report abuse or neglect of children, elders, and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they might be using;
- to notify a person who may have been exposed to disease or maybe at risk for contracting or spreading a disease condition; and
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when equipped or authorized by law.

Health Oversight Activities: We disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved with a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved with the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting information requested.

Law Enforcement: We may release medical information about you if asked to do so by a law enforcement official in response to in response to a court order, subpoena, warrant, summons or similar process to:

- identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances we are unable to obtain the person's agreement;
- about the death we may believe may be the result of criminal conduct;
- about criminal conduct at the facility; or
- 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.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

PATIENT RIGHTS- Your Rights Regarding Medical Information About You

Access: You have the right to look at or request copies of your health information with limited exceptions. This includes medical billing records, but may not include some mental health information. You must submit your request in writing to the Privacy Officer. If you request copies, we retain the right to charge you a reasonable fee to locate, copy and cover postage if you want the copies mailed to you; if we deem it necessary to charge such a fee.

Amendment: You have the right to request that we amend your health information. If you feel that we have medical information about you that is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be in writing and must be submitted to the 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 a 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 the facility;
- 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 have a right to submit a written addendum, not to exceed 250 words, with respect to any item or statement you believe in incomplete or incorrect.

Accounting Disclosures: You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of medical information about you other than for our own uses for treatment, payment, and healthcare operations. To request this list, or accounting of disclosures, you must submit your request in writing to the Privacy Officer. You must state in that request a time period which may not exceed more than six years. You must indicate whether you want your response in paper or electronic form.

Right to Request Restrictions: You have the right to request a restriction or limitation of the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved with your care or payment for your care. We are not required to agree to your request. I we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to the 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;
- to whom you want the limitations to apply (for example, disclosures to your spouse)

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location (for example you may request that we only contact you at home, at work, or by email). To request confidential communications, you must make your request in writing and submit it to the Privacy Officer. We do not require reasons for confidential communication requests. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the facility.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Full Circle Chiropractic
Attn: Privacy Officer: Alysha Arar, DC
28 Fall Street
Seneca Falls, NY 13148
Phone: 315-759-0262
email: ararfullcirclechiro@gmail.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

THIS NOTICE IS IN EFFECT AS OF: 10/01/2018.
REVISED: 10/01/2018

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND PERSONAL HEALTH INFORMATION

Patient's
Name____Date______________

I, ____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this

office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, ____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

my personal health information by your office for treatment, billing / payment and health care

operations as outlined in the NOTICE OF PRIVACY PRACTICES

FULL CIRCLE CHIROPRACTIC

Medical Information Release Authorization form

(HIPPA Release Form)

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Full Circle Chiropractic to use and/or disclose certain protected health information about me to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

This authorization permits Full Circle Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

____

____

____

The information will be used or disclosed for the following

purpose:____

____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ________________________.

I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to the Full Circle Chiropractic Privacy Officer at the below address; provided, however, any revocation is not effective to the extent that Full Circle Chiropractic has already taken action in reliance on it or if the authorization is being obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by federal or state law.

Full Circle Chiropractic will not condition my treatment on whether I provide authorization for the requested use or disclosure, except as permitted by law.

I understand I have the right to:

- inspect or copy the protected medical information to be used or disclosed as permitted under federal or state law; and
- refuse to sign this authorization.

A copy of this authorization will be provided to me after I sign it.

I ___________________________________ have read the above information and authorize Full Circle Chiropractic to use or disclose the identified information to the persons/entities listed above and for the purpose described herein. I understand that, by signing this document, I release and discharge Full Circle Chiropractic and its employees and agents from any liability relating to such use or disclosure and will hold such Full Circle Chiropractic personnel harmless for any use or disclosure made pursuant to this Authorization.

MESSAGES

If you need to reach me regarding upcoming appointments or for billing questions

please: [ ] call [ ] text [ ] email

Phone #:______________________ email:____________________________

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave a message asking me to return your call

[ ] other ____

The best time to reach me is: (*day*) ________________ between (*time*)_______________

Signed by: ______________________________ ________________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ________________________

Print Patient's Name Date

____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Full Circle Chiropractic

28 Fall Street

Seneca Fall, NY 13148

315-759-0262

Full Circle Chiropractic

PATIENT INFORMATION

Title: Please check one Mr. Mrs. Ms. Miss Dr.

First Name: ________________________________ Last Name: ________________________________

Address: ____

City: ____________________________________ State: _____________ Zip Code: _____________

Home phone: ( )______ - ____________ Work Phone: ( )______ - ____________

Cell Phone: ( )______ - ____________ Email: ____

Date of Birth: ______/______/_______ Sex: Male Female Other

Social Security Number: _____-______-______ Marital Status: Single Married Other

Employment status: Employed- *Please circle one:* Full time / Part-time Not employed

Student Other: *Please describe:* ____________________________

EMERGENCY CONTACT INFORMATION

Name: __________________________________ Relationship to patient: _________________________

Address: ____

Phone Number: ( )______ - ____________

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider Name: ____

Address: ____

Phone number: ( )______ - ____________

INSURANCE INFORMATION

Subscriber's Name: ____ Date of Birth: ______/______/_______

Relationship to Patient: _______________________________

Insurance Company: ______________________________________ Group #: ____________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

____

and assign directly to Full Circle Chiropractic all insurance benefits, if any, otherwise payable to and for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: ____ *Date:*___________________________

EMPLOYER DATA

Name: ____

Address: ____

Position Held: ____

Name of contact at place of work: ____

Is it okay to call you at work? YES NO

HEALTH STATUS INFORMATION

Smoking Status

Are you a current smoker? Never Yes No, I've Quit

If yes, how many packs per day? _______________

How long have you been a smoker? ____________

If no, how long ago did you quit? _______________

ALLERGIES

Please list any allergies to medications, substances, or otherwise that you currently have or have experienced in the past:

____

____

____

____

Do you currently take any medication(s) for the above allergies? YES NO

If YES, Please list what you take and how often:

____

____

MEDICATIONS - Please list all current medications, including over the counter and prescriptions. Please include the dosage amount and how often you take it.

____

____

____

____

____

____

SUPPLEMENTS - Please list all natural products (vitamins, herbal medications) that you are currently taking including dose and frequency:

____

____

____

CURRENT COMPLAINT

Please tell us what symptoms brought you here today:

____

____

When did your symptoms start? *Month* __________ *Day* ____________ *Year* ______________

How did your symptoms begin?

____

____

How often do you experience your symptoms? ____

Do your symptoms affect other areas of your body? (*If yes, please list where)*

____

Do the symptoms radiate, shoot, or travel? (*If yes, please list where)*

____

____

What makes your pain **BETTER:** ____

WORSE: ____

What time of day do you experience your symptoms: Morning Afternoon Evening Night

Which time of day is the WORST? __________________

Have you tried any of the following treatments for this complaint?

Prescription Medication   Over the Counter Medication   Acupuncture

Homeopathic Remedies   Massage   Ice   Heat   Chiropractic   Physical Therapy

Other: ______________________________________

Is your condition due to an accident?   YES   NO

To whom have you reported this accident?

Auto Insurance   Employer   Workers Comp   Other__________________   Not Reported

Please describe what you do at work**:** *Ex. sit at a desk, stand at a machine.*
If you do not work please describe if you are sitting/ standing most of the day.

____

____

PLEASE CHECK THE BOXES IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

MUSCULOSKELETAL	CARDIOVASCULAR	ENDOCRINE	RESPIRATORY
No Issues	No Issues	No Issues	No Issues
Osteoporosis	High Blood Pressure	Thyroid Issues	Asthma
Arthritis	Low Blood Pressure	Immune Disorders	Apnea
Scoliosis	High Cholesterol	Hypoglycemia	COPD
Neck Pain	Poor Circulation	Frequent Infection	Hay Fever
Back Pain	Angina	Swollen Lymph Nodes	Shortness of Breath
Hip Disorders	Easy Bruising	Low Energy	Pneumonia
Knee Injuries	Other	Other	Other
Elbow/Wrist Pain	**DIGESTIVE**	**GENITOURINARY**	**SKIN**
TMJ Issues	No Issues	No Issues	No Issues
Foot/Ankle Pain	Anorexia/Bulimia	Kidney Issues	Skin cancer
Poor Posture	Ulcer	Infertility	Psoriasis
Shoulder Problems	Food Sensitivities	Bedwetting	Eczema
Other	Heartburn	Prostate Issues	Acne
NEUROLOGICAL	Constipation	Erectile Dysfunction	Swollen Glands
No Issues	Diarrhea	PMS Symptoms	Rash
Anxiety	Gallbladder Issues	Other	Other
Depression	**SENSORY**	**CONSTITUTIONAL**	
Headache	No Issues	No Issues	
Dizziness	Blurred Vision	Fainting	
Pins and Needles	Ringing in Ears	Low libido	
Numbness	Hearing Loss	Poor Appetite	
Other	Loss of Smell	Fatigue	
	Loss of Taste	Weakness	
	Chronic Ear Infections	Other	

HEALTH HISTORY/MEDICAL CONDITIONS: ***Please check box if you have or have had any of the following.***

	Alcoholism		Diabetes		Hernia		Parkinson's Disease
	Anemia		Emphysema		Herniated Disc		Pinched Nerve
	Benign Tumor		Epilepsy		High Cholesterol		Polio
	Bleeding Disorders		Fibromyalgia		Liver Disease		Skin Disorders
	Breast Lump		Fractures		Lyme Disease		Stroke
	Cancer		Gout		Miscarriage		Tuberculosis
	Chemical Dependency		Headaches		Multiple Sclerosis		Urinary Tract Infection
	Chicken Pox		Heart/Vascular Disease		Neurological Condition		Venereal Disease
	Depression/Anxiety		Hepatitis		Pacemaker		Other

PLEASE EXPLAIN ANY ITEMS YOU CHECKED ON THE PREVIOUS PAGES

ITEM: EXPLANATION:

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

FAMILY HISTORY: Please list any family medical history for Parents, grandparents and siblings. *Such as heart disease, diabetes, high cholesterol, Stroke, arthritis, high blood pressure, cancer.*

____

____

____

____

____

____

____

____

WELLNESS HISTORY

Do you consume alcohol? NO YES: how many drinks per week? ___________

How many cups of caffeinated coffee or tea do you consume each day? __________

How many glasses of soda/pop do you drink each day? ________

How many energy drinks do you consume in a day? _________

How many glasses of water do you drink in a day? __________

How healthy do you feel your diet is? 1=Poor 2 3 4 5=Excellent

Are you concerned about your weight? ____

How stressed do you feel daily? 1=Not stressed 2 3 4 5=Very Stressed

Have you ever accessed or felt the need to access care for mental health? ____________________

How many hours of sleep do you get per night? *Workdays* __________ *"Weekends"* ____________

What do you like to do for exercise? ____

How often do you exercise? ______________________________________

Please list any health goals that you have: ____

____

Please tell me what your goals are for your treatment here:

____

____

____

____

CONSENT FOR CHIROPRACTIC TREATMENT AND PROCEDURES

I understand that:

- During my visit my doctor may recommend that a procedure be performed. Such procedures include but are not limited to: chiropractic adjustment, soft tissue manipulation, stretches and exercises, and application of moist heat.
- The benefits, risks, and alternatives to these procedures will be explained to me at the time of my visit, prior to my doctor performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Procedures are optional. I may choose to decline a procedure for any reason.
- There is no guarantee of results as healthcare is not an exact science and everyone's body is different.
- Some procedures may need to be performed more than once to achieve optimum results.
- If a procedure will incur additional charges, I will be informed before the treatment is applied and will be responsible for the charges.

Signature: ____

PATIENT PERMISSION STATEMENTS

Please check each box indicating your agreement, then please sign the following statement.

Privacy Verification: I know that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf only as needed for treatment or coordination services.

Permission Contact: I grant permission to be called to confirm or reschedule my appointment and have voicemail left for me and to be sent occasional cards, letters, emails or health information (as agreed upon specifically in the Patients Privacy Rights) as an extension of my care in this office.

Payment verification: I acknowledge that I any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services that I receive.

General Verification: To the best of my ability, the information that I have supplied today is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Signature: ____

If not signed by the patient, please indicate the relationship to patient:

Parent or guardian of minor   Personal Representative of person with Disabilities

Name: ____ Date: _________________

Phone: (   )______ - ___________

Email: ____