



## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

### Our Privacy Pledge

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

### Uses and Disclosures

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

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

You have the right to refuse to give us authorization to contact you to regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you.

### Permitted uses and disclosures without your consent or authorization

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

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you as a result of a Workers' Compensation injury.
3. If you are/were a member of the armed forces, as we are required by military command authorities to release your health information.
4. If we provide health care services to you as an inmate.
5. If we provide health care services to you in an emergency or disaster relief situation.
6. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

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

### Your right to revoke your authorization

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

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

PRO FIT REHAB  
2315 W. Arbors Drive Suite #120  
Charlotte, NC 28262

### Your right to limit uses or disclosures

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

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

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



**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

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

You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

**Your right to amend your health information**

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

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

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- \*Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- \*Those disclosures made to you.
- \*Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- \*Those disclosures for national security or intelligence purposes.
- \*Those disclosures made to correctional officers or law enforcement officers.
- \*Those disclosures that were made prior to the effective date of the HIPAA privacy law.

**Our duties**

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

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of your health information in our files.

**Re-disclosure**

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

**To Contact us**

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

PRO FIT REHAB  
2315 W. Arbors Drive Suite #120  
Charlotte, NC 28262  
(704)971-9194

**For more Information or to Report a Problem**

If you have questions and would like additional information, you may contact our practice's Privacy Officer:

Michelle Westerman at (704)971-9194

If you believe your privacy rights have been violated, you can either file a complaint with this office or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR.

The address for the OCR regional office for North Carolina is as follows:

Office for Civil Rights  
U.S. Department of Health and Human Services  
Atlanta Federal Center, Suite 3870  
61 Forsyth Street, S.W.  
Atlanta, GA 30303-8909

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy of this authorization at my request. This notice is effective as of April 14, 2003. This authorization will expire seven years after the date on which you last received services from us.

\_\_\_\_\_  
Patient Name Printed

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

\_\_\_\_\_  
Date

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



Office Use Only  
Patient # \_\_\_\_\_

### New Patient Intake Form

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

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

Referring MD: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of First MD visit for this injury: \_\_\_\_\_ Next MD appointment: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

When did you first notice symptoms of your problem? \_\_\_\_\_

Did your symptoms arise gradually? YES or NO Was there a sudden onset? YES or NO

Was there any trauma/accident that may have caused your complaints/problem? YES or NO

Please elaborate: \_\_\_\_\_

What are your present symptoms? \_\_\_\_\_

How do your present symptoms compare to your original complaint(s)? \_\_\_\_\_

Rate your pain on a scale of 0 (No Pain) to 10 (Excruciating pain that is disabling and requires emergency care.)

At the best moment in the past 48 hrs. \_\_\_\_\_ During the night \_\_\_\_\_ At the worst moment in the past 48 hrs. \_\_\_\_\_

Is your pain (please circle) CONSTANT or INTERMITTENT? Does your pain wake you at night? YES or NO

Does your pain fluctuate depending on your activities? YES or NO

Does your pain follow a pattern where it is worse in the AM or PM (circle one if yes) YES or NO

Does your pain radiate from one area to other areas? YES or NO

What activities increase your pain? \_\_\_\_\_

What activities decrease your pain? \_\_\_\_\_

Do you normally participate in any fitness activities or recreational sports? YES or NO

Please list: \_\_\_\_\_

How have you modified your activities? \_\_\_\_\_

Did your referring MD give you any instructions (i.e. for exercise, weight bearing, weaning from crutches, use of a brace?)

YES or NO Please elaborate: \_\_\_\_\_

Have you missed any work due to this injury? YES or NO

If so, what was your last day of work? \_\_\_\_\_ Date returned to work: \_\_\_\_\_ Worked part-time for period of: \_\_\_\_\_

Have you had any diagnostic tests performed? YES or NO If so, please indicate which test(s) and approximate date(s)

X-Ray: \_\_\_\_\_ MRI: \_\_\_\_\_ CT SCAN: \_\_\_\_\_ Bone Density: \_\_\_\_\_

EMG: \_\_\_\_\_ NCV: \_\_\_\_\_ OTHER(s): \_\_\_\_\_

Have you had surgery for this injury? YES or NO If so, how many have you had? 1 2 3 4

Procedure(s) performed \_\_\_\_\_

Most recent surgery performed? \_\_\_\_\_ Surgeon: \_\_\_\_\_ Date: \_\_\_\_\_

Are you currently taking any medications (for this condition or anything else? YES or NO

Please list the appropriate categories:

Anti-inflammatory(s): \_\_\_\_\_ High Blood Pressure Med(s): \_\_\_\_\_

Muscle Relaxants: \_\_\_\_\_ Bone Density Drugs: \_\_\_\_\_

Pain Medications: \_\_\_\_\_ Beta Blockers: \_\_\_\_\_

Antibiotics: \_\_\_\_\_ Other(s): \_\_\_\_\_



# New Patient Intake Form

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

Have you sought care from any of the following medical providers for this injury/episode? YES or NO

- |                            |                              |                          |
|----------------------------|------------------------------|--------------------------|
| Acupuncturist _____        | Massage Therapist _____      | Physical Therapist _____ |
| Chiropractor _____         | Neurologist _____            | Podiatrist _____         |
| Emergency Room _____       | Occupational Therapist _____ | Other(s) _____           |
| General Practitioner _____ | Orthopedist _____            | _____                    |

## Medical History: Please check if you have had problems with the following:

- |                         |                                |                           |                     |                       |
|-------------------------|--------------------------------|---------------------------|---------------------|-----------------------|
| _____ Anemia            | _____ Cancer                   | _____ Glaucoma            | _____ Kidney        | _____ Skin            |
| _____ Arthritis         | _____ Diabetes                 | _____ Gynecologic         | _____ Liver Disease | _____ Speech          |
| _____ Back Trouble      | _____ Drug or alcohol abuse    | _____ Hearing             | _____ Lung          | _____ Stomach Ulcers  |
| _____ Bleeding disorder | _____ Ear, Nose, Throat, Mouth | _____ Heart               | _____ Mental Health | _____ Stroke          |
| _____ Blood Clots       | _____ Falls/Balance Problems   | _____ High Blood Pressure | _____ Pancreatitis  | _____ Swallowing      |
| _____ Blood Transfusion | _____ Fracture                 | _____ HIV/AIDS            | _____ Prostate      | _____ Thyroid         |
| _____ Breast Cancer     | _____ Gallstones               | _____ Intestinal          | _____ Seizures      | _____ Other - specify |

This intake form was reviewed by: \_\_\_\_\_  
(Therapist Signature)

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



Office Use Only  
Patient # \_\_\_\_\_

## Patient Personal Information

### Patient Information

<b>Patient Name</b>		<b>Home Phone</b>		<b>Cell Phone</b>	
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Marital Status</b>	<b>Spouse Name</b>	<b>Your Date of Birth</b>	<b>Your Social Security #</b>		
<b>Email Address</b>					

### Primary Physician Information

<b>Primary Care Physician</b>		<b>Phone</b>		<b>Fax</b>	
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip</b>

### Emergency Contact Information

<b>Name</b>		<b>Relationship</b>			<b>Home Phone</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Work Phone</b>

### Employment Information

<b>Employer Name (Full or Part-time)</b>		<b>Work Phone</b>			
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip</b>

**Is this Visit a Result of:** Accident: \_\_\_ Work Comp: \_\_\_ Motor Vehicle Accident: \_\_\_ Other: \_\_\_\_\_

<b>If W/C, Employer Name</b>	<b>Contact</b>	<b>Phone Number</b>

#### Assignment of Benefits:

I directly assign all medical benefits, including major medical benefits and Medicare, to Pro Fit Rehab, LLC. I understand that this authorization for assignment remains in effect until I revoke it in writing. A photocopy of this assignment will be considered as valid as this original assignment. I further understand that I am responsible for all incurred charges.

#### Authorization to Receive Therapy

I hereby authorize treatment to be rendered by Pro Fit Rehab, LLC as prescribed by my physician.

#### Authorization to Release Information

I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits or the benefits payable for related services.

**BY VIRTUE OF MY SIGNATURE, I have read and agree to the above acknowledgment/authorizations.**

Insured or Guardian's Signature \_\_\_\_\_

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

# Patient Office Policies

Office Use Only  
Patient # \_\_\_\_\_

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

DOB: \_\_\_\_\_

(Please Print)

**COMMITMENT TO QUALITY CARE:** *We appreciate the confidence that you and your physicians have in Pro Fit Rehab. We hope that you will be pleased with your progress as we strive to provide excellent care. Please let us know if there is anything that we can do to enhance our commitment to excellence.*

## **Scheduling**

After your first visit, your therapist will recommend how often you need to schedule follow-up appointments. We schedule appointments two weeks in advance, so please schedule appropriately. Our office hours are Mon: 7:30-7, Tues: 9-2, Wed 9-7, Thurs 9-12, Fri: 11-6, Sat: By appointment only. **If for any reason you are going to be late for your appointment, please contact us.** We will make every attempt to accommodate your schedule; however, at times we may need to reschedule in order to ensure proper treatment. **Three** consecutively missed appointments, without prior notice, may result in cancellation of all future appointments. Our number is (704) 971-9194.

## **Billing**

Pro Fit Rehab, LLC participates in a variety of insurance plans. Some insurance plans require pre-authorization for therapy services. We work diligently to ensure proper authorization is up to date and encourage you to monitor the number of visits you use. As a courtesy, we verify benefits and file claims. We do everything possible to see that claims are processed accurately. We encourage you to review your insurance benefits as described in your benefits booklet or by calling your insurance company since you are ultimately responsible for any incurred charges. Our patient account representatives will be happy to answer any of your questions.

## **Missed Appointments**

There will be a \$40 FEE for all MISSED APPOINTMENTS WITHOUT prior notice.

## **Insurance**

**Who is responsible for my bill?** Pro Fit Rehab, LLC states that you, the patient, are solely responsible for any charges that you incur with us.

If your insurance carrier has not paid a claim within **60** days of submission, you are responsible to take an active part in the recovery of the claim, and after **90** days, you will be responsible for payment in full for any outstanding balance.

**What if I have insurance?** For your convenience, we will be happy to file your private insurance when provided with the proper information. **All deductible payments must be made prior to insurance submittal.** Co-payments, co-insurance, and items not covered should be paid at the time of service. We will try to provide you with accurate information regarding “in-network” and “out-of-network” coverage. It is ultimately your responsibility to know your network providers. Please contact your insurance carrier if you have questions.

It is the goal of this office to provide you with the finest quality Physical Therapy and/or Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a relationship that works for our mutual benefit.

I have read fully these policies, I understand them completely, and I agree to abide by them.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date