

RHINO CHIROPRACTIC CENTER

NOTICE OF PRIVACY PRACTICES (HIPPA)

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment: We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care options.

Worker's Compensation: We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Open Adjusting Area: This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting may involve more than one patient being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment other arrangement will be made for you.

Phone/Email: As a courtesy to our patients, it is our policy to call your home or email you to reschedule your appointment, confirm our receipt of diagnostic results (such as MRI, etc), or to inform you of an upcoming orientation. If you are not at home, we leave a message on your machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your appointment along with a request to call our office if necessary.

Change of Ownership: In the event that Rhino Chiropractic Center [RCC] is sold or merged with another organization, your health information/record will become the property of the new owner.

Testimonials: Our office is always willing to accept personal testimonials on how chiropractic care in our office has benefited you or your family. From time to time, we will post these testimonials for others to read or include them in our website. Shared personal information such as your full name or age is at your discretion.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that RCC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that RCC amend your protected health information. Please be advised that RCC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of the reasons for our denial and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

RCC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, RCC is required by law to comply with this Notice.

RCC is required by law to maintain the privacy of your health information, and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact **Dr. Damien Ciasullo by calling the office at 215-844-4400**. If Dr. Ciasullo is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

**DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201**

This notice is effective as of ____/____/____ and is reviewed biannually by our HIPPA compliance officer (Dr. Damien Ciasullo).

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Rhino Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (PRINT)

Patient's Signature

Date

Authorized Facility Signature

Date



RHINO CHIROPRACTIC CENTER

NEW PATIENT APPLICATION

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ WHO MAY WE THANK FOR REFERRING YOU? _____

STREET ADDRESS: _____ APT# _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ EMAIL: _____

CELL PHONE: _____ OCCUPATION: _____

WORK PHONE: _____ EMPLOYER: _____

FAVORITE HOBBIES: _____



PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

PHONE NUMBER: _____

ARE YOU EXPECTING? **YES** **NO**

DO YOU HAVE CHILDREN? **YES** **NO** **AGES?** _____

HAVE YOU RECEIVED CHIROPRACTIC CARE PREVIOUSLY? **YES** **NO**

IF YES, YOUR DOCTOR'S NAME? _____

WHEN WAS YOUR LAST ADJUSTMENT? _____

YOUR HEALTH HISTORY

As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. On a daily basis we all experience physical, chemical AND emotional stresses that can accumulate and result in serious loss of health potential. Your answers to the following questions will give us a general view of the stresses that you face in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

YOUR CHILDHOOD (0-17 YRS) ~ CHECK ALL THAT APPLY TO YOU

Vaccinations Antibiotics Surgery Recurrent Illness Serious Falls Smoker
 Active in Sports Car Accident Serious Falls Severe Emotional Stress Alcohol Use Drug Use
 Chiropractic Care

YOUR ADULT YEARS ~ CHECK ALL THAT HAVE APPLIED TO YOU

Neck Pain Shoulder Pain Mid-Back Pain Low-Back Pain Leg Pain/Tingle
 Knee Pain Arm Pain/Tingle Hand Pain/Tingle Head Injuries Sports Injuries
 Headaches Migraines Fatigue Dizziness/Vertigo Balance Issues
 Blurred Vision Ringing in Ears Fainting Sinus Problems Allergies
 Asthma Diarrhea Constipation Difficult Breathing Chest Pain
 Heart Disease High Blood Pressure Stroke Diabetes PMS
 Menopause Breast Lump/Pain Birth Control Pills Infertility Mood Swings
 Depression Cold Sweats Cold Hands Feet Numb Heartburn
 Loss of Smell Jaw Pain Infections Spinal Tap Used Cane/Walker
 Traction Surgery Dislocations Falls/Accidents Broken Bones

ARE YOU CURRENTLY TAKING MEDICATION? **YES** **NO**

NAME(S): _____

AVG. HOURS OF SLEEP PER NIGHT: _____ **TYPICAL SLEEP POSITION:** _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

(If you are here for general wellness, initial here, and go to the Chiropractic Care Agreement! _____)

WHAT IS YOUR PRIMARY CONCERN? _____

PLEASE RATE THE SEVERITY OF THE ISSUE: 1 2 3 4 5 6 7 8 9 10
MILD DEBILITATING

WHAT IS YOUR SECONDARY CONCERN? _____

PLEASE RATE THE SEVERITY OF THE ISSUE: 1 2 3 4 5 6 7 8 9 10
MILD DEBILITATING

ARE THE HEALTH CONCERNS LISTED ABOVE A RESULT OF: AUTO ACCIDENT / WORKER'S COMP/NEITHER

HOW/WHEN DID YOUR SYMPTOMS BEGIN? _____

DESCRIBE THE QUALITY OF YOUR DISCOMFORT:

- Intermittent (25%) Occasional (50%) Frequent (75%) Constant (100%) Burning
 Aching Tingling Numbness Sharp Dull
 Throbbing Varies Improving Rapidly Improving Slowly Slowly Getting Worse
 Rapidly Getting Worse

DOES ANYTHING MAKE YOUR SYMPTOMS FEEL BETTER? _____

DOES ANYTHING MAKE YOUR SYMPTOMS FEEL WORSE? _____

HAVE YOU LOST TIME FROM WORK AS A RESULT OF YOUR SYMPTOMS? YES NO
FROM ___/___/___ TO ___/___/___

HAVE YOU SEEN OTHER CARE PROVIDERS REGARDING THIS? YES NO



CHIROPRACTIC CARE AGREEMENT



When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. **Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom.** It is important that each patient entering a course of care with our office understand both the objective and the method that will be used to attain our goal. Please read the following terms thoroughly in order to understand better what happens during the course of a chiropractic office visit.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation: Vertebral Subluxation is a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

NEW PATIENT ORIENTATIONS: Every other **Thursday**, from 6:00 to 6:30, Dr. Ciasullo holds a Wellness Orientation in the office for new patients and their families. He discusses how you can get the most out of your chiropractic care, the role of your spine in your overall health, and the types of wellness plans which will maximize your health potential. Attendance at this orientation is essential to the beginning of your care at Rhino Chiropractic.

All questions regarding Dr. Ciasullo's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Patient Signature

Date



OFFICE FEE SCHEDULE AND FINANCIAL POLICY

Health Insurance

If you expect your health insurance to contribute to the cost of your care, please allow us to copy your insurance card. We will verify your policy's chiropractic coverage, and provide you with an explanation of your insurance coverage at your report of findings.

Subscriber Name: _____ **Insurance:** _____

Group #: _____ **Policy #:** _____

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Dr. Ciasullo to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Dr. Ciasullo any and all plan documents, insurance policy and/or settlement information upon written request from the doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with Dr. Ciasullo against such insurers and/or employee health care plan in my name but at the doctor's expense.

Signature: _____ **Date:** _____

For Patients with Keystone HMO

A referral from your primary physician is required for any non-emergency services in this office. Please initial next to your choice below:

_____ I acknowledge that I do have a valid, pre-authorized referral for care in this office.

_____ I do not have a referral at this time, and understand I am financially responsible for my care.

For Patients Using Medicare - *Advanced Beneficiary Notice for Non-Covered Services*

I, _____, do understand that Medicare does not cover all of the services rendered during the course of an office visit. Medicare will only cover a spinal adjustment. They will not cover extremity manipulation, therapeutic activities, or exercises. These services may be necessary in aiding or expediting the healing process. These services may or may not be used on every visit. I do understand that in order to accept these services, a fee will be charged in the amount of their regularly scheduled fees on top of any co-pays, coinsurances, deductibles, or any other monies that are directly charged from my insurance company. Therefore, I understand that I have the option to accept or deny these services.

Patient Signature

Date

X-Rays

X-rays are sometimes a necessary tool for Dr. Ciasullo to see and evaluate your posture as well as possible abnormalities. Traditional insurance carriers will not cover X-rays in this office; however, we do have an x-ray machine on site for your convenience as well as to expedite the report of findings process. You have the option to either call your insurance company or the nearest capitated site approved for you to receive X-rays (usually Chestnut Hill Hospital) or you may choose to have X-rays taken here at a cost of \$35.00 per view. Typically, Dr. Ciasullo will take a straight on view and view from the side of each region of your spine that is involved. For example, if you are here for lower back pain, usually 2 views of the low back will be obtained. Please initial next to your choice below:

_____ I understand that X-rays are not covered in this office and that I am financially responsible for payment of any X-rays deemed necessary. I also understand that Dr. Ciasullo will discuss this with me beforehand.

_____ I choose to have X-rays obtained at my nearest capitated site and will need a referral. I understand that this may delay my report of findings and my ability to start chiropractic care immediately.

THANK YOU SO MUCH FOR TAKING THE TIME TO FILL THIS OUT THOROUGHLY.

WELCOME TO THE PRACTICE!

