CARLSON ACUPUNCTURE AND CHIROPRACTIC

HIPAA NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures

Some examples of how we may use or disclose your healthcare information:

- Your health care provider or a staff member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.
- Your health care provider or a staff member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services your receive.
- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If you refuse us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. You are also entitled to an electronic copy of any records maintained in that format.

Permitted Uses and Disclosures Without Your Consent or Authorization

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

- We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.
- We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.
- We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
- We are permitted to use or disclose your health information for state and federal health oversight activities of the healthcare system and government benefit programs.
- We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.
- We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as in inmate.
- We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.
- We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Worker's Compensation rules and regulations.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. Your revocation request will not be honored if:

- We have already released your health information before we receive your request to revoke your authorization.
- 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.
- Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure

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

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

Patient Signature:_____ Date: _____

ACUPUNCTURE TREATMENT SIDE EFFECTS

****Although side effects from Acupuncture treatment are very rare, there is a possibility of them happening.**

1. Dizziness, lightheadedness, fainting.
    a. The reason for this is usually if you haven't eaten within the previous 2-3 hours.
2. Bruising at the site of the Acupuncture needle.
    a. This bruising is self limiting and will resolve itself in a few days.
3. Very slight bleeding (a drop or two) after the needle is removed.
    a. This is common with one or two spots with each treatment, but stops immediately with light pressure, even for those that are on a blood thinner medication.
4. Small hard lumps at the site of the Acupuncture needle followed by possible bruising
    a. Again self limiting and will resolve in a few days.
5. The level of discomfort from the insertion of the Acupuncture needle in the skin range from painless to a slight, temporary discomfort. It is not uncomfortable as most would perceive it to be.

If any of these possible side effects concerns you at all, please discuss them with Dr. Carlson prior to your treatment.

Signed:_____ Date:_____

ATTENTION PATIENTS:

Due to the fact that we treat many patients with allergies, please be courteous to these people and refrain from wearing perfumes and colognes to your appointments.

Dr. Carlson reserves the right to refuse treatment to any patient who does not reasonably comply with this request.

115 N. Galena Ave.
Dixon, IL 61021
Phone: (815) 677-9498
Fax: (815) 994-4917

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

OFFICE CHARGES

Chiropractic & Acupuncture New Patient Exam: $125

Chiropractic New Patient Exam: $95.00

Acupuncture New Patient Exam: $54.00

Re-Activation Examination: $30
(this fee applies when a patient hasn't been seen for 1 year)

Adjustment: $52

Acupuncture: $47

Rapid Release: $25

Cupping: $20
(Chinese medicine technique for muscle spasms and/or muscle sprain or strains)

Traction Table: $25

Muscle Testing: $47

Bemer Mat: $20

Patient is responsible for payment of any cost associated with the collection on past due balances, including collection fees, finance charges and attorney fees.

Signature:_____ Date:_____