

PATIENT REGISTRATION

Name _____ Social Security # _____ Date: _____
 Last First MI

Address _____
 Number Street City ST Zip

Sex: M / F Age: _____ Birth Date: _____ Height: _____ Weight: _____

Home # _____ Work # _____ Cell# _____ Single/Married/Divorced/Widow

Employer _____ Type of Work you do _____

In case of emergency contact _____ Relationship _____ Phone # _____

Email: _____ How did you hear about us? _____

Preferred way of communication: Home / Cell / Work / Email / Text

HEALTH INSURANCE INFORMATION

Health Insurance Company: _____ Name of Insured: _____

Member #: _____ Group#: _____ Phone #: _____

TREATMENT OF MINOR

Not applicable

Guardian's Name _____ Social Security # _____
 Relationship to Patient _____ Home # _____ Work # _____
 Address (if different) _____
 Place of Employment _____

I hereby authorize Pow-Her Chiropractic and all it designates to treat this minor who is legally under my guardianship.

Signature _____ Date _____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and that it is my responsibility to notify this office of any changes. I further will not hold my doctor or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

I hereby authorize Pow-Her Chiropractic and or any of its subsidiaries to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I hereby authorize and assign directly to Pow-Her Chiropractic all insurance benefits, if any, payable to services rendered. I understand that I am responsible for all charges whether or not paid by insurance.

Signature Date

Witness Date

CLINICAL HISTORY

Circle if you have a history of any of the following:

<u>Skin</u> Rash Eczema Itching Skin Changes Redness Bruise easily Hair changes	<u>Neurologic</u> Headache Dizziness Fainting Convulsion Nervousness Confusion Numbness Paralysis Cold/tingling extremities	<u>Eyes/Ears</u> Hearing trouble Ringing Vision Trouble Pain Discharge	<u>Musculoskeletal</u> Neck pain Upper back pain Low back pain Upper extremity pain Lower extremity pain Jaw pain General stiffness Walking problems	<u>Nose</u> Pain Bleeding Sinus Problems Infections No Smell	<u>Mouth/Throat</u> Sores Bleeding Tonsillitis Enlarged Glands No Taste Abnormal Taste Bad breath
<u>Heart Lungs</u> Cough Wheezing Asthma Difficulty Breath Swollen UE/LE Blue UE/LE Varicosities Murmur Chest Pain Palpitations	<u>Breasts</u> Lumps Redness/itching Pain Dimpling Discharge	<u>Stomach/Digestion</u> Decreased Appetite Increased Appetite Abdominal Pain Hemorrhoids Excess Gas Vomit Diarrhea Constipation	<u>Genitourinary</u> Inability hold urine Painful Urination Frequent Urination Bedwetting Irregular Menstruation Painful Menstruation Abnormal Vaginal Bleeding Prostate Problems Sterility	<u>Endocrine</u> Thyroid Heat/Cold intolerance Sugar in urine Goiter Tremor	<u>Psychological</u> Anxiety Depression Phobia Mood Swings ADD/ADHD Mental Disorders

Arthritis / Anemia / Cancer / Diabetes / Epilepsy / Gout / Gallbladder / Hypertension / Influenza / Kidney disease / Lupus / Nausea / Vomiting / TB / Polio / Migraines / Mumps / Multiple Sclerosis / Psoriasis / Rheumatoid Arthritis / Scoliosis / Hernia / Lyme Disease

Broken Bones Y/N Explain: _____

Pregnant: Y/N _____ Last Mammogram: _____ Last prostate exam: _____

Doctor's you have seen in past 2 years: _____

Surgeries you have had: _____

Allergies: _____

List Drugs or Supplements: _____

Children: (# & ages) _____

Smoker packs per day _____ Caffeine (soda, coffee, tea) cups per day _____

Alcohol per day/week: _____ Commute: _____

Hobbies: _____

List health conditions family members have/had:

Mother: _____ Father: _____

Sister: _____ Brother: _____

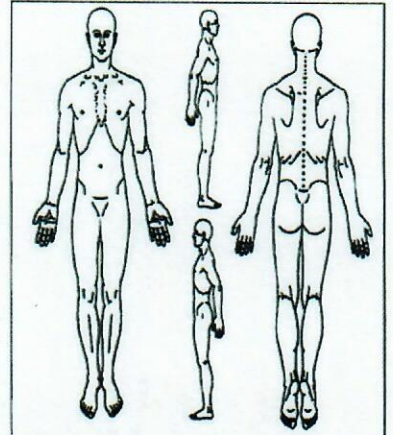
Grandparents: _____ Children: _____

Have you ever been to a chiropractor? Y/N If yes explain: _____

Signature _____ Date _____

INJURY SURVEY

1. Please outline the area(s) of your discomfort on the diagram.
2. When did your symptoms begin: Month _____ Day _____ Year _____
3. Where did your symptoms begin? Home, Work, Accident _____
4. How did you hurt yourself: _____
5. What helps the pain feel better: Moving/Sit/Laying/Rest/Exercise/Nothing
Other: _____ Medications _____
6. What makes the pain worse: Sitting/Standing/Laying _____
7. Rate your overall pain on a scale 1-10 (0-well to 10-severe)
morning _____ afternoon _____ evening _____ overall _____



Please Circle Areas of Complaint:

	Mild	Mod	Severe	Occasional	Intermittent	Frequent	Constant	1-10
Headaches								
Neck Pain								
R/L Shoulder Pain								
R/L Arm								
R/L Elbow								
R/L Forearm								
R/L Wrist								
R/L Hand								
Upper Back Pain								
Midback Pain								
Lower Back Pain								
Buttock Pain								
R/L Hip Pain								
R/L Thigh Pain								
R/L Knee Pain								
R/L Ankle Pain								
R/L Foot Pain								
Other:								

Quality of pain: Ache/Dull Sharp Shooting Stabbing Throbbing
 Numb/Tingling Sore Deep Electric Fiery

8. Have you ever had this before: Y/N When? _____
9. Have you seen anyone else for the pain: Date/Provider/Treatment _____
10. Have you missed work due to the pain? _____ Have you lost sleep due to the pain? _____
11. Have you been limited in any activities due to this pain? _____
12. Do you exercise? ()Yes ()No Has your exercise been hindered by this injury? ()Yes ()No
 Type of Exercise: _____

WORK INJURY INFORMATION

Date: _____
Name: _____ **Date of Accident:** ____/____/____
Employer: _____ **Employer Phone:** _____
Employer Address: _____ **Employer Fax:** _____
Your Occupation: _____
Date Injured: ____/____/____ **Time:** _____ AM/PM
Last Date Worked: ____/____/____ **Are you presently off Work?** Yes No
Has the injury been reported to your Employer? Yes No
Name of person injury was reported to: _____
Claim #: _____
Insurance Company: _____
Claim Adjuster: _____ **Phone #:** _____
Where Injured: _____ **City:** _____ **State:** _____ **Zip:** _____
Length of Time you worked there prior to the injury: _____
Type of work being done at time of injury: _____
Describe the injury: _____

Been evaluated or treated by another doctor in relation to this injury? Yes No
If yes, please list doctor s name and address: _____

What type of treatment did you receive? _____

What medications are you taking? _____

Have you had physical therapy? If yes, please state type of treatment you received? _____

Prior to this accident, have you ever had any physical complaints similar to what you have now? If yes, please describe: _____

Were any of these complaints the result of a previous accident or injury? If yes, please describe: _____

Have you contacted an Attorney? Yes No
Attorney's name? _____
Address: _____
Phone # _____

Pow-HER Chiropractic
Dr. Cheryl Lee-Pow

600 Jefferson Plaza Suite 350
Rockville MD 20852

www.powherchiro.com
301-279-9009

PATIENT CONSENT AND FINANCIAL POLICIES

CONSENT FOR EXAMINATION & TREATMENT: I voluntarily consent to receive chiropractic/medical treatment and diagnostic testing at Pow-HER Chiropractic. I know that I am responsible for all charges incurred at this facility. If I have no insurance benefits, payment is due at the time of service. My balance owed to this office will not exceed \$50.00 unless I am placed on an authorized payment plan.

INSURANCE ASSIGNMENT OF BENEFITS: In order to receive the best care possible within your benefits, it is important that you comply with our financial policy: I assign payment by my insurance company directly to Pow-HER Chiropractic. If my current policy prohibits direct payment to this office, I instruct my insurance company to make the check out to me and mail it to Pow-HER Chiropractic.

Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection. If your insurance company sends you checks, it is your responsibility to deliver them to our office. I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents.

Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment unless I am placed on an authorized payment plan. It is illegal to waive these fees. I understand that I am financially responsible for charges and co-payments not covered by my insurance carrier. In automobile cases, I will bring my Personal Injury Protection forms (from my automobile insurance carrier), no matter who caused the accident, to this office within four (4) weeks or I am personally responsible for my bill.

If my insurance carrier has not paid a claim within sixty (60) days of submission, I agree to take an active part in the recovery of my claim. If my insurance carrier has not paid a claim within ninety (90) days, I am responsible for the balance owed.

When my schedule of visits is one time per month or less, I am aware that this office will no longer accept insurance assignment. Pow-HER Chiropractic will provide me with an insurance form if I request it.

In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for all reasonable cost of a collection agency, attorney, and / or court costs.

RELEASE OF INFORMATION: I authorize the use and disclosure of health information that pertains to me for treatment, payment, or official operations. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. In addition I authorize Pow-HER Chiropractic to share findings/send reports to my family physician or other health care provider listed on my health history form.

I understand that I may revoke this authorization at any time by signing the revocation of my copy of this form and returning it to Pow-HER Chiropractic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire at the end of my treatment cycle. I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that Pow-HER Chiropractic will receive compensation for the uses and disclosures that I have authorized.

I authorize Pow-HER Chiropractic to leave any message necessary at my home/work in regards to any appointments, billing or insurance issues that may accrue.

I authorize Pow-HER Chiropractic to allow my spouse or anyone listed below to schedule or cancel an appointment on my behalf.

Patient's or Patient's Guardian's Name (Signature)

Patient's or Patient's Guardian's Name (Please Print)

Pow-HER Chiropractic

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www.powherchiro.com

Dr. Cheryl Lee-Pow

Rockville MD 20852

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CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body. The incidence of complications associated with chiropractic services are extremely rare, anyone undergoing adjusting or manipulative procedures should know the rare possible hazards and complications that may be encountered or result during the course of care. These include but are not limited to fractures, disc injuries, strokes, dislocations, sprains and those which relate to physical aberrations unknown or undetectable by the doctor. Sometimes the response is phenomenal. _____

Initial Here

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I understand and give the doctor permission and authority to care for me in accordance with the chiropractic test, diagnosis and analysis. The practice of chiropractic or medicine is not an exact science and that the care may involve the making of judgments based on the facts known to the doctor. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, or an undesirable result does not necessarily indicate an error in judgment or treatment. In addition there is no guarantee as to results with respect to any course of care or treatment.

RESULTS

The purpose of chiropractic services is to promote natural health. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the Informed Consent Form.

Signature: _____ Date: _____

Witness: _____ Date: _____

Pow-HER Chiropractic
600 Jefferson Plaza, Suite 350
Rockville, Maryland, 20850
Phone: 301-279-9009 Fax: 301-279-9008

Notice of Privacy Practices

Effective **Monday, September 23, 2013**

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

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information - The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate - The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative - The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations - The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities - The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence - We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities - We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings - We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes - We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety - We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Cheryl Lee-Pow

Address: 600 Jefferson Plaza Suite 350 Rockville MD 20852

Telephone No.: 301-279-9009

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

Roland-Morris Questionnaire

Patient name: _____ Signature: _____ Date: _____

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my sock (or stockings) because of the pain in my back.
- I can only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Patient name: _____ Signature: _____ Date: _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Unable to work at all*
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Need help with all my personal care*
3. Does your pain interfere with your traveling?
Travel anywhere I like 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Only travel to see doctors*
4. Does your pain affect your ability to sit or stand?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot sit /stand at all*
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot do at all*
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot do at all*
7. Does your pain affect your ability to walk or run?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot walk/run at all*
8. Has your income declined since your pain began?
No decline 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Lost all income*
9. Do you have to take pain medication every day to control your pain?
No medication needed 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *On pain medication throughout the day*
10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *See doctors weekly*
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Never see them*
12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Total interference*
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Need help all the time*
14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Severe depression / tension*
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Severe problems*



600 Jefferson Plaza Suite 350
Rockville MD 20852
301.279.9009 Office 301.279.9008 Fax
www.powherchiro.com

No Show/Late Cancellation "Fees" Policy

This policy, **effective 7/1/2015**, has been established to help Pow-Her Chiropractic provide better service to all its patients, by giving everyone the opportunity to be treated at the earliest possible time.

It is necessary for appointments to be made in order to see patients in an efficient manner. However, "No-shows" and "Late-cancellations" create problems, not only from a financial nature to Pow-Her, but deprives other patients from an earlier opportunity for medical treatment and improvement to their health. Some of these other patients may require critical treatment of an urgent nature.

A "No-show" is missing a scheduled appointment without calling the office, while a "Late-cancellation" is cancelling an appointment with less than 24 hours before the appointment.

Pow-Her recognizes that emergency situations do arise when an appointment cannot be kept or timely notice provided. These situations would be considered on a case by case basis as to whether fees should be waived.

Please understand that insurance companies view this charge to be the patient's responsibility.

In the interest of informing patients of this policy, we would waive the fees for the first missed appointment, but would take the opportunity then to ensure that the patient who missed the first appointment is provided with a written copy of the policy.

Fees to be Charged: \$25.00 will be charged for 2nd and each subsequent "No-show" or "Late-cancellation," both of which are defined above.

Patient Signature: _____

Date: _____

Signature of Pow-Her: _____

Date: _____