For the office of: Sue Mulcahey, DC, LLC
NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license & insurance card (if applicable)

Please print and fill in all of the blanks. Today's Date _____
Name _____ Nickname/Preferred Name_____
Age _____Male or Female _____ Person responsible for account?_____
Address_____City _____State_____Zip_____
Home phone (____)_____ Work Phone (____)_____Ext._____
Cell phone (_____)_____ Best number to contact you? Home Work Cell
May we leave voicemail on Home/Cell phone Circle YES NO *Permission can be changed at any time.
Date of Birth _____/_____/_____
Status [ ] Married–Spouse's name_____ [ ]Single [ ]Divorced [ ] Widowed
Are you a student? Circle YES NO If yes, full time or part time?_____
Patient's Employer _____ Full Address_____
Occupation _____ [ ] Full time [ ] Part time [ ] Disability [ ] Retired
Work activity [ ] Heavy lifting [ ] Light Labor [ ] Mostly sitting [ ] Walking/moving [ ]Driving
Emergency Contact_____ Your relationship_____ Phone_____

Email Address_____@_____Signature_____
(By my signature above, I give this office permission to contact me through electronic mail. Emails are used for communication purposes only (if needed) and we will send you a monthly newsletter.

Information if the patient is not the guarantor of the insurance policy:
Insured's Name _____ Insured's Phone _____
What is <u>your</u> relationship to the insured? _____
Insured's Full Address _____
Insured's Date of Birth _____/_____/_____ Insured's SS# _____-_____-_____
Insured's Employer _____Address _____

Information about your Primary Care Doctor:
Name of Family Doctor _____Phone _____
Address _____ City _____ State _____Zip_____
Do we have your permission to contact this doctor to share information and to let them know your progress with chiropractic care? Circle one: YES NO
How did you hear about this office? _____

<u>Please read before signing:</u>
We appreciate that you have chosen us for your health care needs. If there is insurance coverage that will be submitted for processing for treatment and services received at this practice, patient understands that insurance benefits are not guaranteed and coverage for payment is determined when claims are received and processed. Any verification of benefits provided is only an estimate of coverage. We will try to verify your insurance coverage and benefits for you, however we cannot guarantee the accuracy of what someone from your insurance company may tell us. Patients are encouraged to contact insurance payers directly to learn more about your individual policy benefits and limitations. Please sign below to acknowledge patient responsibility for the patient portion of insurance charges and/or payment in full for non-covered items or services. If there is no insurance coverage, patient is responsible for the balance due for services at the time of service for each visit.

PATIENT SIGNATURE _____ Date _____/_____/_____
This page was reviewed (with additions initialed) by Dr. Mulcahey_____

Patient Name_____

Patient Health Survey

Circle yes or no to the following conditions that apply to you.
When applicable, give explanations on the line provided. All information that you provide is confidential.

Yes No List any allergies/sensitivities to medications or ointments _____
Yes No Weight change (loss or gain) more than 10 lbs. in past year_____
Yes No Have you seen a doctor in past year other than for cold/flu?_____
Yes No List hospitalizations in past five years _____
Yes No Has a doctor recommended any tests/surgeries in past five years? _____
_____
Yes No When was your last chiropractic visit? _____
Yes No Fever, chills, night sweats, dizziness, fainting, shortness of breath _____
Yes No Head, neck, ear or eye pain, headaches or ringing in the ears _____
Yes No Bleeding disorders, arthritis, leukemia or skin disorder _____
Yes No Neck problems, swallowing difficulties, thyroid condition _____
Yes No Hoarseness, sore throat, allergies, regular colds, flu or asthma _____
Yes No Injury to the neck, whiplash, pinched nerves or numbness of neck _____
Yes No Chest pain, heart problems, irregular beats, pacemaker, stroke _____
Yes No Lung problems, congestion, cancer, tuberculosis or lung disease _____
Yes No Do you smoke? _____ If yes, how many packs per day?_____
Yes No Alcoholism or drug addiction to social or prescription drugs_____
Yes No Nausea, vomiting, ulcers, colitis, spastic colon or diverticulitis_____
Yes No Gallbladder, pancreas, liver or other digestive condition _____
Yes No Hemorrhoids, rectal bleeding or frequent constipation or diarrhea_____
Yes No Male/female genital disorders, surgeries, diseases, sexual problems, prostate problems
_____
Yes No Fatigue, anxiety, depression _____
Yes No Diabetes (Type 1 or Type 2) kidney problems _____
Yes No Any fractured or broken bones _____
Yes No Malformation of any bones or joints _____
Yes No Injury to the mid back, pinched nerves or severe muscle spasms _____
Yes No Scoliosis, curvature of the spine or structural problems _____
Yes No Injury or tendonitis of shoulder, elbow, wrist, hand or fingers _____
Yes No Carpal tunnel syndrome, rotator cuff, bursitis or tennis elbow_____
Yes No Foot problems, deformities, surgeries to the feet or ankles_____
Yes No Venereal diseases, HIV/AIDS, herpes, hepatitis, other communicable disease_____
Yes No Any work related injuries pending now or in the past _____
Yes No Have you ever had a disability rating for an injury in the past?_____
Yes No Any condition, surgery or disease not described above _____

Explain any “yes” answers and list any other health related conditions or problems that we should know about:

_____
_____
_____

PATIENT SIGNATURE _____Date _____/_____/_____
This page was reviewed (with additions initialed) by Dr. Mulcahey_____

Patient Name_____

Explain your use of the following: (Circle answer)

Alcohol Never Seldom Occasionally Often Daily
Tobacco Never Seldom [ ] _____ cigarettes a day
Social Drugs Never Seldom Occasionally Often Daily
Coffee Never Seldom Occasionally Often Daily _____cups/day
Tea Never Seldom Occasionally Often Daily _____cups/day
Soda Never Seldom Occasionally Often Daily _____cans/day
Water Never Seldom Occasionally Often Daily _____glasses/day
Exercise Never Light Moderately Heavy _____times a week Type_____
Stress Level Extremely High High Moderate Slight None

Describe any medications or vitamin/supplements that you are currently taking:

Name of medication Dosage Frequency Reason for taking medication

_____
_____
_____
_____
_____
_____

For use by doctor: Dates Med List was updated by patient: ___/___/___ Initial_____
___/___/___ Initial _____ ___/___/___ Initial _____ ___/___/___ Initial_____

List all surgeries that you have had in the past:

Type of surgery When Reason performed Result

_____
_____
_____
_____

Indicated which of the following test(s) you have had in the past:

X-rays _____ When _____ Where _____
CT scan or MRI _____ When _____ Where _____
Myelogram _____ When _____ Where _____
Ultrasound _____ When _____ Where _____

Indicate any or all treatments that you have already had for you present condition:

[ ] Prescription drugs [ ] Surgery [ ] Chiropractic care [ ] Physical Therapy

FOR WOMEN ONLY: Can you become pregnant? Circle Yes No
Date of your last mammogram _____Date of your last pap smear _____
Are you now or is it possible that you are pregnant? Circle Yes No
Date of your last period _____ Any menstrual/hormone issues?_____

PATIENT SIGNATURE_____ Date ____ /_____/_____
This page was reviewed (with additions initialed) by Dr. Mulcahey_____

Patient name_____

Family History: Identify conditions that you or any of your family members have now or have previously had. **PGM**=Paternal Grandmother **PGF**=Paternal Grandfather **F**=Father **M**=Mother **MGM**=Maternal Grandmother **MGF**= Maternal Grandfather **B**=Brother **S**=Sister **X**=Myself

Condition	Relation to you	Condition	Relation to you
Heart Disease		Glaucoma	
Stroke		Bleeding Disorders	
Diabetes (Type I or 2?)		Kidney Disease	
Deep Vein Thrombosis		Thyroid Disease	
Cancer: Type	Type	Type	Type

Other conditions not listed_____

_____

Is your mother living? Age?_____ If no, her age at death_____ Cause of death_____
Is your father living? Age?_____ If no, his age at death _____ Cause of death_____

What activities of daily living are difficult for you to perform due to your condition?

[ ] Climbing stairs	[ ] Standing for prolonged periods	[ ] Pushing or pulling
[ ] Lifting	[ ] Getting in/out of auto or chair	[ ] Kneeling
[ ] Yard/outdoor work	[ ] Household chores or light work	[ ] Bending over

List any additional information that may help us with your health care needs:

_____

_____

Tell us about why you made an appointment to see us today:

Health concern(s) today_____

_____

When did symptoms begin?_____ What initiated symptoms?_____
Have you previously been treated by another provider? Yes or No Is so, by whom?_____
Treatment received:_____
Have you had any bad reactions to previous treatment? Yes No Explain_____
If this is a recurrence, when did you initially notice this problem?_____
Has it worsened over time? Circle: Yes No Same Better Worse _____
How long does it last? Circle: All Day Hours Minutes Other_____
Is this condition interfering with activities? Circle: Work Sleep Daily Routine Recreation Other_____
Describe your symptoms. (Circle all that apply) Pain Sharp Dull Numbness Tingling Aching Burning Stabbing Throbbing Stiffness Other:_____
What makes the problem worse? Circle: Standing Sitting Lying Bending Lifting Twisting Other_____
Does anything relieve your symptoms? Yes: _____ No, Nothing Helps
Do you have any other conditions/symptoms that may be related to current symptoms? _____
Have you ever been in an auto accident or other physical trauma? When?_____
Are you left or right handed? Circle LEFT RIGHT

What would you *like to be able to do* but are unable to do so now?_____

PRINT NAME OF PATIENT _____ **DATE** _____/_____/_____
Signature of patient (or parent/legal guardian) _____

Thank you for taking the time to complete this paperwork!

This page was reviewed (with additions initialed) by Dr. Mulcahey_____

Informed Consent to Chiropractic Care
(Please read carefully before signing.)

Chiropractic Adjustment: The doctor will use her hands or a mechanical device in order to adjust your spinal joints. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a 'click' or a 'pop' as well as a movement of the joint. Various ancillary procedures such as electric simulation therapy, traction or hot/cold packs may also be used.
Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been described as 'rare'. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be 'rare'.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following risks of my case explained to me. If you/and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.

Patient Authorization: I have read or have had read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

_____
PRINT NAME of Patient (or Guardian of minor)

_____ _____/_____/_____
SIGNATURE of Patient (or Guardian of minor) **Date**

Back Index Name_____ Date_____

This questionnaire is to see how your back affects your everyday life. Please answer each section by marking the one statement that applies to you. If two or more statements in one section apply, mark the **one statement** that most closely describes your pain.

Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is very severe and does not vary

Sleeping

0. I get no pain bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than 25%.
3. Because of pain my normal sleep is reduced by less than 50%.
4. Because of pain my normal sleep is reduced by less than 75%.
5. Pain prevents me from sleeping at all.

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases pain immediately.

Walking

0. I have no pain while walking.
1. I have some pain while walking but it doesn't increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of pain, I am unable to do some washing and dressing without help.
5. Because of pain, I am unable to do any washing or dressing without help.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights.

Traveling

0. I get no pain while traveling.
1. I get some pain while traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not cause me to seek alternative forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except that done while lying down.
5. Pain restricts all forms of travel.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life if normal but increases the degree of pain.
2. Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Neck Index Name_____ Date_____

This questionnaire is to see how your neck pain affects your everyday life. Please answer each section by marking the one statement that applies to you. If two or more statements in one section apply, mark the **one statement** that most closely describes your pain.

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Reading

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of severe neck pain.
5. I cannot read at all because of neck pain.

Concentration

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I have a lot of difficulty concentrating when I want.
4. I have a great deal of difficulty concentrating when I want.
5. I cannot concentrate at all.

Work

0. I can do as much work as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Personal Care

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of my self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive my car at all because of neck pain.

Recreation

0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I am able to engage in most but not all my usual recreation activities because of neck pain.
3. I am only able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

Headaches.

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Headache Disability Index

Name _____Date _____Age_____ Score Total: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache(s): [1] One per month [2] more than 1 but less than 4 per month [3] more than one per week
2. My headache is [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully) The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES," "SOMETIMES," or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
1. Because of my headaches, I feel handicapped.	[ ]	[ ]	[ ]
2. Because of my headaches, I feel restricted in performing my routine daily activities	[ ]	[ ]	[ ]
3. No one understands the effect my headaches have on my life.	[ ]	[ ]	[ ]
4. I restrict my recreational activities (eg. sports, hobbies) because of my headaches.	[ ]	[ ]	[ ]
5. My headaches make me angry.	[ ]	[ ]	[ ]
6. Sometimes I feel that I am going to lose control because of my headaches.	[ ]	[ ]	[ ]
7. Because of my headaches, I am less likely to socialize	[ ]	[ ]	[ ]
8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	[ ]	[ ]	[ ]
9. My headaches are so bad that I feel that I am going to go insane.	[ ]	[ ]	[ ]
10. My outlook on the world is affected by my headaches.	[ ]	[ ]	[ ]
11. I am afraid to go outside when I feel that a headache is starting.	[ ]	[ ]	[ ]
12. I feel desperate because of my headaches.	[ ]	[ ]	[ ]
13. I am concerned that I am paying penalties at work or home because of my headaches.	[ ]	[ ]	[ ]
14. My headaches place stress on my relationships with family or friends.	[ ]	[ ]	[ ]
15. I avoid being around people when I have a headache.	[ ]	[ ]	[ ]
16. I believe my headaches are making it difficult for me to achieve my goals in life.	[ ]	[ ]	[ ]
17. I am unable to think clearly because of my headaches.	[ ]	[ ]	[ ]
18. I get tense (eg. muscle tension) because of my headaches.	[ ]	[ ]	[ ]
19. I do not enjoy social gatherings because of my headaches.	[ ]	[ ]	[ ]
20. I feel irritable because of my headaches.	[ ]	[ ]	[ ]
21. I avoid traveling because of my headaches	[ ]	[ ]	[ ]
22. My headaches make me feel confused.	[ ]	[ ]	[ ]
23. My headaches make me feel frustrated.	[ ]	[ ]	[ ]
24. I find it difficult to read because of my headaches.	[ ]	[ ]	[ ]
25. I find it difficult to focus my attention away from my headaches and on other things.	[ ]	[ ]	[ ]

NOTICE OF PRIVACY PRACTICES
Sue Mulcahey, DC, LLC

This Notice of Privacy Practices ("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.

Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**
  You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Official at 2711 W. Sixth Street, Lawrence, KS 785-832-9355.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

We ask that you **exercise your rights in writing.** We offer forms and templates to help you exercise your privacy rights and to help us protect your health information.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

NOTICE OF PRIVACY PRACTICES

Sue Mulcahey, DC, LLC

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices is effective as of: October 1st, 2013

The Notice of Privacy Practices was last revised on 10/01/2013

Sue Mulcahey, DC, LLC
2711 W. 6th Street Suite E
Lawrence, KS 66049
785-832-9355

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

This notice is for patients that self-pay.

Under the law, health care providers need to give patients **who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like initial examinations and adjustments. Other charges may include fees for any needed therapy, acupuncture, supplies etc.

- If you schedule a health care service at least three business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within one business day after scheduling. If you schedule a health care service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within three business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule a service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate in writing within three business days after you ask.

- If you receive a bill from any provider/facility that is at least $400.00 more than your Good Faith Estimate from that provider or facility, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

Call us if you have questions about your bill at 785-832-9355
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.