

Oler Chiropractic & Wellness Care  
Dr. Ronald E. Oler, DC

Acknowledgement of Receipt of "Patient Notice of Privacy Rights"  
Summary Notice (Effective 9-19-2011)

**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.**

As our patient, under HIPAA, the federal privacy act, you have specific privacy rights. This notice is provided in 2 documents. This 1<sup>st</sup> page summarizes how we handle your health information, and contains the acknowledgement of receipt that we are required by law to attempt to obtain. The 2<sup>nd</sup> document contains the details about our privacy policies and procedures. We are required to have and provide a notice for our patients detailing how medical information about them may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is provided to all patients at their initial visit to our office beginning 4-14-03. The terms of our notice may change. Any change in our notice will be posted in our waiting rooms. This is a summary notice of your rights.

A summary of your rights includes your right to:

- a. restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
- b. receive confidential communications in an alternate form or location
- c. inspect, copy, and amend protected health information (you may be billed for the cost of copying)
- d. know about any unauthorized disclosure of protected health information or data breach of our practice management system which involves your protected health information.
- e. have a copy of our patient privacy notice

**You must be given a copy of the "PATIENT NOTICE OF PRIVACY RIGHTS with REGARD TO HEALTH CARE INFORMATION", from our receptionist.**

**Signature Acknowledgement:**

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from Ronald E. Oler, DC dba Oler Chiropractic & Wellness Care

DATE	PATIENT PRINTED NAME	PATIENT SIGNATURE
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Patient Representative Signature (Required if minor or an adult who is unable to sign)	MEDICAL RECORD #
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**Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices**

This notice and acknowledgement was mailed to the patient's home address on \_\_\_\_/\_\_\_\_/\_\_\_\_.

The acknowledgement was not signed because:

The patient refused to sign the acknowledgement

The patient was undergoing emergency treatment

\_\_\_\_\_ : Other

Signature: _____	_____
Signature of staff member	Date

**Neck and Upper Extremity Complaints:** (check all that apply)

If None – fill out right side of form only

- Headache  Jaw  Neck  Upper Back  Shoulder
- Arm  Hand  Other \_\_\_\_\_ Onset Date: \_\_\_\_\_

- Gradual Onset or
- Injury –What Happened

Pain or Symptom Intensity for this area 1 (discomfort) to 10 (severe pain)

1	2	3	4	5	6	7	8	9	10
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Describe the pain? (Check all that apply)

- dull  sharp  throbbing  burning  deep
- aching  tingling  stabbing  cramping  numbness  radiating

What activities aggravate this area of complaint? (Check all that apply)

- sitting  standing  walking  bending  stooping  lifting
- sleeping  sneezing  coughing  straining  reaching  twisting
- looking up  looking down  movement  rest  lying face-up  driving
- typing  scooping  house chores  exercise  lying face-down  stairs

Do any of the following give you any relief from this symptom? (Check all that apply)

- sitting  standing  lying  knees bent up  support
- no movement  movement  heat  ice  pain relieving cream
- ibuprofen  medication  rest  stretching/exercise

**Low-Back and Lower Extremity Complaints:** (check all that apply)

If None – fill out left side of form only

- Mid-Back  Low Back  Hip  Pelvis  Leg  Knee
- Foot  Other \_\_\_\_\_ Onset Date: \_\_\_\_\_

- Gradual Onset or
- Injury –What Happened

Pain or Symptom Intensity for this area 1 (discomfort) to 10 (severe pain)

1	2	3	4	5	6	7	8	9	10
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Describe the pain? (Check all that apply)

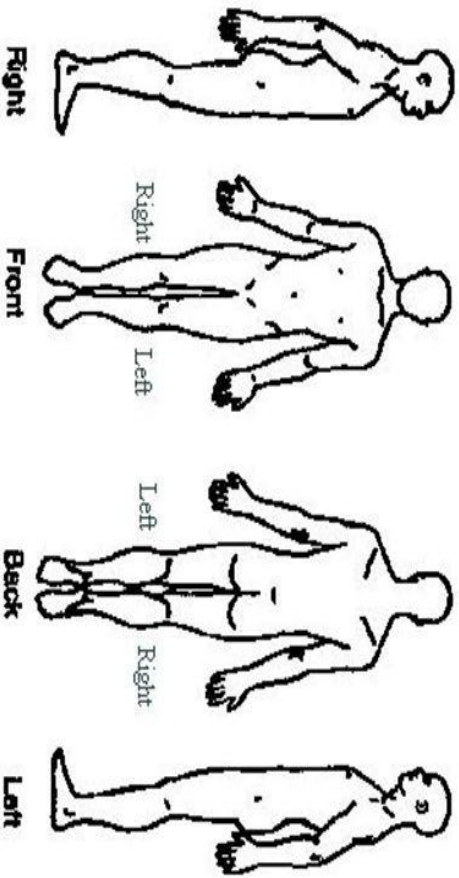
- dull  sharp  throbbing  burning  deep
- aching  tingling  stabbing  cramping  numbness  radiating

What activities aggravate this area of complaint? (Check all that apply)

- sitting  standing  walking  bending  stooping  lifting
- sleeping  sneezing  coughing  straining  reaching  twisting
- looking up  looking down  movement  rest  lying face-up  driving
- typing  scooping  house chores  exercise  lying face-down  stairs

Do any of the following give you any relief from this symptom? (Check all that apply)

- sitting  standing  lying  knees bent up  support
- no movement  movement  heat  ice  pain relieving cream
- ibuprofen  medication  rest  stretching/exercise



Shade any areas of pain or other symptoms on the body diagram to the left

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

Signature: \_\_\_\_\_

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

# New Patient Health History

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Today's Date  /  Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home email \_\_\_\_\_ Work Email \_\_\_\_\_

Which email address would you like us to use to communicate with you? (check one)  Home  Work

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  /  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish  
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi  
 Persian  Urdu  Gujarati  Armenian  I choose not to specify

**Verification Question** (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet?     In what city were you born?     What high school did you attend?
- What is your favorite movie?     What is your mother's maiden name?     On what street did you grow up?
- What was the make of your first car?     When is your anniversary?     What is your favorite color?

**Verification Answer to the Chosen question:** \_\_\_\_\_  
(answer needs to be at least 6 letters long)

**Do you currently smoke tobacco of any kind?**     Yes     Former smoker     Never been a smoker

**If yes, how often do you smoke:**     Current every day smoker     Current sometimes smoker

**If yes, what is your level of interest in quitting smoking?**

- 0     1     2     3     4     5     6     7     8     9     10
- No interest Very Interested

**Current medications, including dosage if known.**

**If there are no current medications, check here:**

1) \_\_\_\_\_ 5) \_\_\_\_\_

2) \_\_\_\_\_ 6) \_\_\_\_\_

3) \_\_\_\_\_ 7) \_\_\_\_\_

4) \_\_\_\_\_ 8) \_\_\_\_\_

**List any known allergies you have had to any medications.**

**If no allergies are known, check here:**

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

**Has any doctor diagnosed you with Hypertension presently?**     Yes     No    If yes, describe: \_\_\_\_\_

**Has any doctor diagnosed you with Diabetes presently?**     Yes     No    If yes, what kind?     Type I     Type II

**If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?**     Yes     No     Not Sure

**If yes, other comments regarding Diabetes:** \_\_\_\_\_

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?**     Yes     No

**To be performed by clinic staff:**

**Height:** \_\_\_\_\_ inches    **Weight:** \_\_\_\_\_ pounds    **BP:** \_\_\_\_\_ / \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your  Work  Sleep  Daily routine

Have you had this or similar condition in the past?  Yes  No

Have you been treated by an MD for this condition?  Yes - Name of MD \_\_\_\_\_  No

Have you ever been treated by a Chiropractor before?  Yes  No Name of DC \_\_\_\_\_

Do you have or have ever had any of the following diseases or conditions? (circle any that apply)

- |                      |                    |                           |                         |                       |                    |
|----------------------|--------------------|---------------------------|-------------------------|-----------------------|--------------------|
| Lower Back Problems  | Frequent Neck Pain | Severe/Frequent Headaches | Artificial Bones/Joints | Rheumatoid Arthritis  | Low Blood Pressure |
| Heart Attack         | Stroke             | Heart Surgery             | Pacemaker               | Mitral Valve Prolapse | Sinus Problems     |
| Artificial Valves    | Heart Murmur       | Rheumatic Fever           | Congenital Heart Defect | Glaucoma              | Kidney Problems    |
| Psychiatric Problems | Seizures/Epilepsy  | Fainting                  | Breathing Difficulties  | Emphysema             | Asthma             |
| HIV+/AIDS            | Ulcers             | Colitis                   | Hepatitis               | Tuberculosis          | Shingles           |
| Cancer               | Chemotherapy       | Radiation                 | Alcohol Abuse           | Drug Abuse            | Anemia             |
| Osteoporosis         | Other: _____       |                           |                         |                       |                    |

List any Surgeries with dates:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

List and past serious accidents with dates:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

Do you Take Supplements or Vitamins?  Yes  No

Do you exercise regularly?  Yes  No \_\_\_\_\_ times per week or month for \_\_\_\_\_ minutes or hours

Are you wearing  Heal Lifts  Arch Supports  Inner Soles  Sole Lifts

Is your mattress comfortable?  Yes  No

Women Only Are you taking Birth Control Pills/Depo Provera, etc.?  Yes  No

Are you pregnant?  Yes  No If yes, due date: \_\_\_\_\_ Are you currently nursing?  Yes  No

# **OLER CHIROPRACTIC WELLNESS CARE**

1867 Main St. #D1  
PO BOX 845  
Groveland, CA 95321  
(209) 962-0662

## **Informed Consent: Chiropractic Adjustments & Care**

Patient Name \_\_\_\_\_ Acct.No. \_\_\_\_\_

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by Dr. Ron E. Oler, who now or in the future will treat me in this office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I understand that I will have an opportunity to discuss with the doctor and/ or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care; however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures. I intend to this consent form to cover the entire course of treatment for my present condition and for any future condition{s} for which I seek treatment.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Ron E. Oler

\_\_\_\_\_  
Date

## Privacy Policy – Uses and Disclosure of Your Protected Health Care Information

### Treatment

We may disclose your health care information to other healthcare professionals & staff within our practice for the purpose of treatment, payment, or healthcare operations. "Healthcare professionals within our practice," may include contracted Chiropractors in the event of Dr. Oler's absence due to vacation, sickness, or other emergency situations. We use a sign in sheet to document your appt.

### Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Oler Chiropractic & Wellness Center for health care services rendered. If you pay for your health care services personally, we may, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

### Workers' Compensation

Our office may disclose your health information as necessary to comply with State Workers' 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 or of your death.

### Judicial & Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

### 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.

### Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### Deceased Persons

We may disclose your health information to coroners or medical examiners.

### Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

### Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

### Communication

We may contact you as described below. As a courtesy to our patients, we may call your home or send you an email on the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering 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 scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Our office sends a Newsletter via email. You may choose to opt-out at any time using the link on the newsletter.

Our office may send you an electronic Clinical Document Summary in order to comply with new HIPAA/ARRA regulations. This information is encrypted, password protected and will be delivered via HealthVault.

### Change of Ownership

In the event that Oler Chiropractic & Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

### Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Oler Chiropractic & Wellness Center 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 Oler Chiropractic & Wellness Center amend your protected health information. Please be advised, however, that Oler Chiropractic & Wellness Center 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 our denial reason(s) 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 made by Oler Chiropractic & Wellness Center.

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**

Oler Chiropractic & Wellness Center 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, Oler Chiropractic & Wellness Center is required by law to comply with this Notice.

Oler Chiropractic & Wellness Center 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 questions about any part of this notice or if you want more information about your privacy rights please contact Pam Oler by calling this office at 209-962-0662. If Pam Oler is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

## **Complaints**

Complaints about your Privacy rights or how Oler Chiropractic & Wellness Center has handled your health information should be directed to Pam Oler by calling this office at 209-962-0662. If Pam Oler 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

# **Oler Chiropractic & Wellness Center**

## **Notice of Privacy Practices**

Our office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Oler Chiropractic & Wellness Center**  
**Dr. Ronald E. Oler, DC**

**18687 Main Street, Suite D1**  
**PO Box 845**  
**Groveland, CA 95321**  
**Phone: 209.962.0662**  
**Fax: 209.962.0455**

**[info@OlerChiropracticWellness.com](mailto:info@OlerChiropracticWellness.com)**  
**[www.OlerChiropracticWellness.com](http://www.OlerChiropracticWellness.com)**

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This notice is effective as of 09/19/2011