INITIAL NEW PATIENT ENTRANCE INFORMATION

513-988-9735 Dr. Robert B. Sheely -- Chiropractic Physician

Call-In Date: _____ Initial Appointment _____ _____ _____

First Name: _____ Middle Initial: ____ Last Name: _____

SS# _____ Street Address: _____

City: _____ State: ____ ZIP: _____ Home Phone: _____

Birthdate: _____E-mail: _____ Website: _____

Age: ____ Cell Phone:_____ Marital Status: _____ Number of Children: _____

Occupation: _____ Title: _____

Employer or Mother's Name (if minor): _____ Employer/Mother Phone _____

Employer/Mother Address: _____

Family Physician: _____ Phys City: _____ Phys Phone: _____

Spouse or Father Name (if minor): _____ Sp/Father Occupation: _____

Spouse/Father Birthdate: _____ Spouse/Father Employer: _____

Spouse/Father Employment Phone: _____ Spouse/Father SS#: _____

Relative Not Living With You _____ Relative's Phone: _____

Relative's Address: _____

Referred by: _____ Refferral Information: _____

Main Complaint: _____

Is your condition due to injury or sickness caused by work? _____

Have you lost days from work? _____ What Dates? _____

Date Symptoms Began: _____

Name of Insurance Company: _____ Policy #: _____

Address of Ins. Co.: _____

Type of Insurance Applicable to My Care (mark all that apply):

☐ Preferred Provider Organization In-Network ☐ Preferred Provider Organization Out-of-Network

☐ Major Medical ☐ Medicare ☐ Medicaid--Medical Card ☐ Workers Compensation ☐ HMO

☐ Personal Injury- Medical Payment-Med Pay-(Auto accident-Drivers fault or other drivers fault-you have full coverage)

☐ Personal Injury- Bodily Injury - (Auto accident-Other drivers fault-other driver probably cited-ultimately responsible)

☐ Personal Injury - Home Owners - (Injured in your home or another persons home)

☐ Personal Injury - Business Owners - (Injured in a place of business)

INSURANCE

THIS OFFICE WILL PROCESS YOUR INSURANCE FORMS UPON REQUEST. WE WILL DO OUR UTMOST TO PROVIDE SUFFICIENT INFORMATION TO YOUR CARRIER TO OBTAIN PAYMENT FOR YOUR TREATMENT. WE HAVE FOUND THAT, IN SOME INSTANCES, HOWEVER, INSURANCE COMPANY WILL DENY, REDUCE, OR FAIL TO MAKE TIMELY PAYMENTS, DESPITE OUR BEST EFFORTS TO DEMONSTRATE THE NECESSITY FOR CARE. PATIENTS ARE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY ITEMS ISSUED AND NOT COVERED BY THE INSURANCE COMPANY AND FOR YEARLY DEDUCTIBLE IF APPLIED TO ANY SERVICES RECEIVED HERE.

ACCEPTANCE AS PATIENT

I UNDERSTAND AND AGREE THAT THE DOCTORS OF THE SHEELY CHIROPRACTIC CLINIC HAVE THE RIGHT TO REFUSE TO ACCEPT ME AS A PATIENT AT ANY TIME BEFORE TREATMENT BEGINS. THE TAKING OF A HISTORY AND CONDUCTING OF A PHYSICAL EXAMINATION ARE NOT CONSIDERED TREATMENT, BUT ARE PART OF THE PROCESS OF INFORMATION GATHERING SO THAT THE DOCTOR CAN DETERMINE WHETHER TO ACCEPT ME AS A PATIENT

WITH MY SIGNATURE I HEREBY STATE THAT ALL OF THE ABOVE INFORMATION THAT I HAVE WRITTEN/OR VERIFIED IS TRUTHFUL AND ACCURATE. I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

_____ _____

DATE SIGNATURE

OFFICE USE: [ ] CASE ACCEPTED_____ [ ] CASE REFERRED_____ FILE _____
NO._____ [ ] INSURANCE VERIFIED_____ [ ] CONFIRMED WITH PATIENT
_____

INITIAL NEW PATIENT ENTRANCE INFORMATION

513-988-9735 Dr. Robert B. Sheely -- Chiropractic Physician

ACCIDENT INFORMATION

How did the accident occur? _____

When did the accident occur? _____

Where did the accident occur? _____

If Auto Accident, who was cited? _____

Was your condition due in any way to your work? _____

Have you lost any days from work? _____

What Dates? _____

Name: _____ SS#: _____

Address: _____ Birthdate: _____

_____

The above accident information is true and correct. I am stating this information for file and insurance filing purposes in order to expedite the correct handling of any and all insurance claims relating to my care.

_____ _____

Signature Date

Patient Number: _____

Dr. Robert B. Sheely -
Chiropractic Physician

Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name:_____ **File #**_____ **Date:**_____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY

25 ☐ The pain comes and goes and is very mild
26 ☐ The pain is mild and does not vary much
27 ☐ The pain comes and goes and is moderate.
28 ☐ The pain is moderate and does not vary much
29 ☐ The pain comes and goes and is very severe
30 ☐ The pain is severe and does not vary much

SECTION 2 – PERSONAL CARE

31 ☐ I would not have to change my way of washing or dressing in order to avoid pain.
32 ☐ I do not normally change my way of washing or dressing even though it causes some pain
33 ☐ Washing and dressing increase the pain but I manage not to change my way of doing it
34 ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it
35 ☐ Because of the pain I am unable to do some washing and dressing without help.
36 ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING

37 ☐ I can lift heavy weights without extra pain.
38 ☐ I can lift heavy weights but it causes extra pain.
39 ☐ Pain prevents me from lifting heavy weights off the floor.
40 ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e g on a table).
41 ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
42 ☐ I can only lift very light weights at the most.

SECTION 4 - WALKING

43 ☐ I have no pain on walking.
44 ☐ I have some pain on walking but it does not increase with distance
45 ☐ I cannot walk more than one mile without increasing pain
48 ☐ I cannot walk more than 1/2 mile without increasing pain
49 ☐ I cannot walk more than 1/4 mile without increasing pain
50 ☐ I cannot walk at all without increasing pain

SECTION 5 - SITTING

51 ☐ I can sit in any chair as long as I like
52 ☐ I can only sit in my favorite chair as long as I like
53 ☐ Pain prevents me from sitting more than one hour
54 ☐ Pain prevents me from sitting more than half hour.
55 ☐ Pain prevents me from sitting more than 10 minutes
56 ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

57 ☐ I can stand as long as I want without pain
58 ☐ I have some pain on standing but it does not increase with time
59 ☐ I cannot stand for longer than one hour without increasing pain.
60 ☐ I cannot stand for longer than ½ hour without increasing pain.
61 ☐ I cannot stand for longer than 10 minutes without increasing pain
62 ☐ I avoid standing because it increases the pain straight away

SECTION 7 - SLEEPING

63 ☐ I get no pain in bed.
64 ☐ I get pain in bed but it does not prevent me from sleeping well
65 ☐ Because of pain my normal night's sleep is reduced by less than 1/4
66 ☐ Because of pain my normal night's sleep is reduced by less than 1/2
67 ☐ Because of pain my normal night's sleep is reduced by less than 3/4
68 ☐ Pain prevents me from sleeping at all

SECTION 8 – SOCIAL LIFE

69 ☐ My social life is normal and gives me no pain
70 ☐ My social life is normal but increases the degree of pain
71 ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g dancing, etc
72 ☐ Pain has restricted my social life and I do not go out very often.
73 ☐ Pain has restricted my social life to my home
74 ☐ I have hardly any social life because of the pain

SECTION 9 - TRAVELING

75 ☐ I get no pain while traveling.
76 ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
77 ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel
78 ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
79 ☐ Pain restricts all forms of travel.
80 ☐ Pain prevents all forms of travel except that done lying down

SECTION 10 – CHANGING DEGREE OF PAIN

81 ☐ My pain is rapidly getting better
82 ☐ My pain fluctuates but overall is definitely getting better
83 ☐ My pain seems to be getting better but improvement is slow at present
84 ☐ My pain is neither getting better nor worse
85 ☐ My pain is gradually worsening
86 ☐ My pain is rapidly worsening

Pain Scale:

Rate the severity of your pain by checking one box on the following scale.

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Patient Name _____ **File #** _____ Date _____

Confidential Consultation and History

Dr. Robert B. Sheely - Chiropractic Physician

Patient Area – Please Check Appropriate Boxes

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm/Elbow
☐	☐	Hand Pain
☐	☐	Wrist pain
☐	☐	Upper back pain
☐	☐	Low Back Pain
☐	☐	Pain Upper leg or Hip
☐	☐	Pain Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Jaw Pain
☐	☐	Swelling/Stiff Joints
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus/(ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight Gain
☐	☐	Abnormal Weight Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue

Women Only

☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Pregnancy
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replace

☐	☐	Loss of Bladder control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregularity
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Indigestion
☐	☐	Depression

Doctor Use Only - To Expand and Clarify your History, complaints, conditions, and Review of systems

Confirm symptoms / Confirm history of symptom onset / Most recent trauma or injury –

Present Complaint _____

Date Original onset: __/__/__ Date Recent Exacerbation __/__/__

Mechanism of onset _____

Duration:_____ Frequency: _____ Location: _____

Radiation of Symptoms:_____ Initial Treament date_____

1c. Intensity of pain lowest and highest -no pain – 1 2 3 4 5 6 7 8 9 10 unbearable

1d. Your symptoms are [ ] Decreasing [ ] not changing

1e. Symptoms worse in [ ]morn [ ]Afternoon [ ]night [ ]Increase during Day/[ ]same

2. When began date _____ how begin _____more above

Previous Diagnostics/treatment received/response –

Diagnostics:

Treatment:

3. Been treated In Past Same Condition [] yes [] no If yes by whom? [ ] DC [ ] MD [ ] DO [ ] PT [ ] OT [ ] Other _____ Currently seen? _____When and What Treatment? __/__/__

4. Been treated for this episode? [] yes [] no If yes by whom? [] DC [] MD [] DO [] PT [] OT [] Other _____ Currently seen? _____When and What Treatment? __/__/__

Activities of daily living that increase/decrease symptoms –

5. makes better? []nothing [] Lay/down []Walk []Stand []Sit []move/exer [] Inact

6. makes worse? []nothing [] Lay/down []Walk []Stand []Sit []move/exer [] Inact

7. Rate Stress level – []liitle none []minimal moderate []greatly stressed

8 General Phys Activity [] No reg exer []Light exer moder exer []Strenuous exer

9.. Affect Ability to be Active? [] no eff [] some rest []limited ass [] Ass often [] sig inability [] total disablied

Activities of daily living patient would like to do, but can't –

10. Activity at work [] sit more than 50% []light manual []heavy [ ]repeat motion

Previous musculoskeletal complaints / Previous Accidents –

Any Previous Problem in this current problem area? [ ] Yes [ ] No – If Yes Explain:

Patient Name: _____ File #: _____ Date: _____

PATIENT AREA – PLEASE CHECK APPROPRIATE BOXES

PAST	PRESENT	
☐	☐	TAKING MEDICATION(S)
☐	☐	HOSPITALIZATION/SURGICAL
☐	☐	AORTIC ANEURYSM
☐	☐	HIGH BLOOD PRESSURE
☐	☐	ANGINA
☐	☐	HEART ATTACK
☐	☐	STROKE
☐	☐	ASTHMA
☐	☐	CANCER
☐	☐	TUMOR
☐	☐	PROSTATE PROBLEMS
☐	☐	BLOOD DISORDER
☐	☐	EMPHYSEMA (LUNG DISORDER)
☐	☐	ARTHRITIS
☐	☐	RHEUMATOID ARTHRITIS
☐	☐	DIABETES
☐	☐	EPILEPSY
☐	☐	ULCER
☐	☐	LIVER / GALL BLADDER
☐	☐	KIDNEY STONES
☐	☐	HEPATITIS
☐	☐	BLADDER INFECTION
☐	☐	KIDNEY DISORDERS
☐	☐	COLITIS
☐	☐	IRRITABLE BOWEL
☐	☐	HIV/AIDS
☐	☐	SYSTEMIC LUPUS
☐	☐	OTHER _____

LIFESTYLE

☐	☐	TOBACCO
☐	☐	ALCOHOL
☐	☐	DRUG OR ALCOHOL DEPENDENCE
☐	☐	COFFEE/TEA/CAFFEINATED SOFT DRINKS PER DAY _____

STOP - DOCTOR ONLY AREA

PAST	2 MONTHS TO PRESENT	
☐	☐	**SEVERE TRAUMA**
☐	☐	**DIRECT HEAD TRAUMA**
☐	☐	**HX STROKE**
☐	☐	**LOST CONSCIOUSNESS**
☐	☐	**DIZZY-POOR BALANCE**
☐	☐	**POOR COORDINATION**
☐	☐	**NUCHAL RIGIDITY**
☐	☐	**PERSISTENT NIGHT PAIN**
☐	☐	**NIGHT PAIN WORSE**
☐	☐	**DYSPHAGIA**
☐	☐	**FEVER**
☐	☐	**RECENT INFECTION**
☐	☐	**SADDLE ANESTHESIA**
☐	☐	**BLADDER DYSFUNCTION**
☐	☐	**RECENT WEIGHT LOSS**
☐	☐	**OSTEOPOROSIS DX**
☐	☐	**HISTORY OF CANCER**
☐	☐	**DIFFICULTY BREATHING**
☐	☐	**ABDOMINAL PAIN**
☐	☐	**CORTICOSTEROIDS**
☐	☐	**ANTICOAGULANTS**
☐	☐	**BIRTH CONTROL MED**

DOCTOR USE ONLY - TO EXPAND AND CLARIFY YOUR HISTORY, COMPLAINTS, CONDITIONS, AND REVIEW OF SYSTEMS

REVIEW PREVIOUS MEDICAL HISTORY / REVIEW OF SYSTEMS –NOTE *RED FLAGS*

CHILDHOOD DISEASES: MEASLES_____ MUMPS_____ CHICKEN POX_____
OTHERS_____
UNUSUAL CHILDHOOD DISEASES:_____
ADULT ILLNESSES OR CONDITIONS:
_____
SURGERIES/HOSPITALIZATIONS:_____
_____
FRACTURES:_____
_____
MEDICATIONS:_____
_____
ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATIONS?_____
LAST PHYSICAL (DATE) _____
FINDINGS:_____

REVIEW PRESENT EXERCISE PROGRAM, HOBBIES, LEISURE ACTIVITIES, SPORTS –

PRESENT OCCUPATION / SUMMARIZE JOB TASKS –
11. OCCUPATION:

12. [] FULL TIME NO RESTRIC []FT /W RETRIC []PT NO RESTRIC [] PT W/ RESTRIC
[] OFF WORK DUE TO RESTRIC []FT HOMEMAKER [] UNEMP []RET []FT STUDENT []OTHER _____

UNCOMPLICATED V. COMPLICATED / RED FLAGS –

FAMILY HISTORY
- ☐ CANCER
- ☐ RHEUMATOID ARTHRITIS
- ☐ DIABETES
- ☐ HEART PROBLEMS
- ☐ LUNG PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ EPILEPSY
- ☐ CHRONIC BACK PROBLEMS
- ☐ CHRONIC HEADACHES
- ☐ LUPUS
- ☐ OTHER CONDITIONS

_____
_____

PATIENT SIGNATURE _____ **DOCTOR SIGNATURE** _____

Date Given: _____	***RECORDS RELEASE*** *Please complete and return on your next visit to our office*	*Date Returned:* _____

The staff and the doctors of Dr. Robert B. Sheely, Inc, want to provide you with the most complete care possible. Part of this process is in making sure that we understand your present condition. We want to know as much as possible about any previous care that you may have received for the condition you want us to treat in this office. Please list any previous doctors, clinics, hospitals, or therapists that you have seen prior to coming to Dr. Robert B. Sheely, Inc.

1. NAME _____ ADDRESS _____
   CITY _____ STATE _____ ZIP _____
   PHONE _____ DATES SEEN _____
   Were you referred to this Doctor/Hospital? _____ If Yes, By Whom _____
   Did this Doctor/Hospital refer you to anyone else or for other tests? _____
   If Yes, Who or what tests? _____
   _____

2. NAME _____ ADDRESS _____
   CITY _____ STATE _____ ZIP _____
   PHONE _____ DATES SEEN _____
   Were you referred to this Doctor/Hospital? _____ If Yes, By Whom _____
   Did this Doctor/Hospital refer you to anyone else or for other tests? _____
   If Yes, Who or what tests? _____
   _____

3. NAME _____ ADDRESS _____
   CITY _____ STATE _____ ZIP _____
   PHONE _____ DATES SEEN _____
   Were you referred to this Doctor/Hospital? _____ If Yes, By Whom _____
   Did this Doctor/Hospital refer you to anyone else or for other tests? _____
   If Yes, Who or what tests? _____
   _____

I give permission for Dr. Robert B. Sheely, Inc., to obtain copies of treatment records from the above providers.

Patient Name _____ _____ _____
(Signature – Must be 18) *Date*

Address _____ *City* _____ *State* _____ *ZIP* _____

Daytime Phone: _____ *Patient Number:* _____

Dr. Robert B. Sheely – Chiropractic Physician
608 W. State Street 1010 Cereal Ave, #305
Trenton, OH 45067 Hamilton, OH 45013
Phone: 513-988-9735
Fax: 513-988-9220
drrob@sheelychiro.com
www.sheelychiro.com

HIPAA Notice of Privacy Practices

Dr. Robert B. Sheely, Inc., is committed to maintaining the privacy of your protected health information known as (PHI), which is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, this Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice carefully and if your should have any questions or concerns about this Privacy Notice please do not hesitate to contact our privacy officer...Cathy Barnhill, at 608 West State Street, 513-988-9735.

This office is required by law to abide by the terms of this Notice of Privacy Practices as well as abiding by any other applicable state laws that may govern privacy practices and/or the scope of the practice of chiropractic. Our office may change and/or modify the terms of this Notice at any tie and the new Notice will be effective for all PHI that we obtain at that time. Our office and/or doctor will provide you with a copy of our Notice of Privacy Practices and make a good faith effort to obtain your written acknowledgement of our Notice, no later than the date of your first service delivery effective April 14, 2003. We will also keep you notified of any changes to our Notice of Privacy Practices and if requested by you our office will provide you with an updated copy of same.

Uses and Disclosures of PHI:
Our office may use and disclose of your PHI for health care delivery purposes, which is known as treatment, payment and health care operations (TPO). Your PHI may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the doctor's practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every single possibility of how your PHI may be used or disclosed. We can assure you that your doctor and his office staff will do everything possible to maintain the confidentiality of your PHI. Listed below are some of the more common types of uses and disclosures of your PHI that our office is allowed to make without your consent and/or authorization. Any other uses and/or disclosures other than those listed below will only be made with your written authorization.

Treatment—Your PHI may be used and disclosed for the coordination or management of your health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding you or the referral of you from one health care provider to another.
Payment—Your PHI may be used and disclosed for payment which encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and provide benefits under the plan and to obtain reimbursement for the provision of health care.
Health Care Operations—Your PHI may be used and disclosed for healthcare operations for certain administrative, financial, legal and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment.
Emergency Situations—Our office and/or doctor may use or disclose your PHI in an emergency treatment situation. If an emergency situation happens to arise we are not required to obtain a written acknowledgement from you of our Notice of Privacy Practices until after the emergency situation has ended.
Minimum Necessary Standard—Our office and/or staff will make reasonable efforts to limit the use and disclosure of and requests for your PHI to the minimum necessary to accomplish the intended purpose.
Employee limitations—Your doctor will also limit the use and disclosure of your PHI to members of his or her workforce to those who may need access to your PHI for treatment, payment and health care operations.
Public Health Purposes and Activities—Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations or interventions. In addition, your PHI may be disclosed for public health activities like child abuse or neglect, quality, safety or effectiveness of a product or activity regulated by the FDA and persons at risk of contracting or spreading disease as well as workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose.
Business Associated Contract—A business associated is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity i.e.: health care provider, health care plan or clearinghouse. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurances from the business associated that the business associate will safeguard your PHI it receives or creates from any misuse and will use the information only for the purposes for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administration of the business associate.
Research Purposes—Your PHI may be used or disclosed for research purposes which has been de-identified and/or you have authorized the use and disclosure of your PHI.
Workers' Compensation Purposes—Due to the variability among State laws, the privacy Rule permits disclosure of your PHI for purposes as authorized by and to the extent necessary to comply with workers' compensation laws without your authorization and no minimum necessary determination is required.
Marketing Purposes—Frequently, we have patients whose chiropractic experience would be helpful to others to share in educating others about our chiropractic services. We may request that you would allow us to share your experience with others. This request will include a specific release signed by you explaining the use of your PHI for this purpose. i.e. (your picture and chiropractic experience story in a frame hanging in our office, on our website, e-mailed, or mailed to others in our office newsletter) Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to-face communication or a communication involving a promotional gift of nominal value by the covered entity i.e.: Health care provider, health care plan or clearinghouse. Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. Occasionally, this type of marketing has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows. 1. A communication is not marketing if it is made to describe a health-related product or service that is provided by or included in a plan of benefits of the covered entity making the communication. 2. A communication is not marketing if it is made for treatment of the individual. 3. A communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual. Note: Besides from the above exceptions any other form of marketing would require your authorization to use and disclose your PHI.
Personal Representative—Your PHI may be used and disclosed, under State law, to a person who is authorized to act on your behalf in making your health care related decisions.
Legal Proceedings—Your PHI may be disclosed if requested by any judicial or administrative proceedings court order, a subpoena, law enforcement purposes etc.
Miscellaneous uses and disclosures of PHI—We may use a sign-in sheet at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when your doctor is ready to see you. We may use and disclose your PHI to contact you to remind you of your appointment. We are also allowed to use and disclose your name and address to send you a newsletter about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you.

Notice for: _____ Date: _____ Patient Number: _____

Patient's Rights to Access and Control their PHI:
The Privacy Rule allows you certain rights with regards to your records, which are as follows.
You have the right to review and receive copies of your records as it relates to your own care.
Your request would have to be put in writing and the law requires that your doctor respond within 30 days of your request. In addition, your doctor is allowed to deny you access to your records, but only if it is going to cause you harm or someone else harm. If your doctor denies you access to your records the denial has to be referred to a health care review professional, which would be the privacy officer who was designated. Your doctor is allowed to charge a copy fee, which should not exceed State law allowance.
You have the right to request that the use and disclosure of your PHI be restricted.
This means you have the right to request restrictions on how your doctor will use or disclose your PHI about treatment, payment and health care operations.
Your doctor is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor agree on.
You have the right to request to receive confidential communications from your doctor by alternative means or at an alternative location.
Your doctor must accommodate your request, provided it is reasonable, and you clearly state that not doing so could endanger you.
You have the right to request amendments (changes) to your records.
If changes are made to your record it does not mean that your doctor will destroy his or her records or your doctor will rewrite their records. It means that your doctor will add anaddendum to your current records to reflect your changes. Your doctor has the right to deny or reject your request to change your records, but you have the right to submit a statement in the medical record that you disagree. Your doctor also has the right to add to the record a rebuttal
You have the right to receive your doctor's Notice of Privacy Practices.
The law requires that your doctor provide you in writing their policy on how they are protecting and using your PHI.
You have the right to revoke an authorization.
The revocation can be done at any time provided it is in writing. There is an exception to revocation that is if your doctor has taken any action in reliance o the use or disclosure indicated in the doctor's Authorization Notice.

Patient's Right to File a Complaint:
If you believe, that nay of your Privacy Rights have been violated by us you can file a written complaint with our Privacy Officer (please see our privacy officer to obtain a complaint form). Your complaint must be filed within 180 days of when you knew or should have known that the act had occurred. In addition, you can also file a written complaint either on paper or electronically with the Office of Civil Rights (OCR). Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices:

I _____, acknowledge that I have read and was given a copy of Dr. Robert B. Sheely, Inc.'s Notice
Print Patient's Name

of Privacy Practices and fully understood same and have had all my questions answered to my satisfaction.

_____, _____
Patient's Signature Date

_____, _____
Signature of Privacy Officer Date

****

E-mail Use and Privacy Policy for Dr. Robert B. Sheely, Inc.

Dr. Robert B. Sheely, Inc., uses the latest in communication and Internet technology in its practice. Because of this, it is necessary to establish understandings and rules of communication concerning e-mail usage.

1. We will NEVER provide your e-mail to any other company or individual.
2. Because the use of e-mail can help us lower our operation costs and ultimately your costs, we would like to use it in as many ways as possible.
3. We would like to provide helpful health tips to you on a periodic basis through e-mail. This information will help you with your care and help you regain and maintain your health.
4. You will always have the opportunity to choose not to receive e-mail from us at anytime.
5. You may use e-mail to ask a question or request an appointment. Please allow up to three days for a response.
6. We may use e-mail as a way of communicating patient education information.
7. Employees are not permitted to use your e-mail for other than office related communications unless you have given them permission.

I have read the above e-mail policy for Dr. Robert B. Sheely, Inc., and I agree with it in the use of my e-mail address.

My e-mail address is (Please print very clearly) _____

My first name _____ Last Name _____

Date _____

Signature _____

Patient Number: _____