
Fall 2019

An electronic copy of this manual is also available on the Life Chiropractic College West website
A Message from the Health Center’s Vice President of Clinical Operations

Welcome to the Monte Greenawalt Health Center at Life Chiropractic College West (the Life West Health Center). As you begin your clinical journey, you are starting to see your goals and dreams of becoming a chiropractor realized. Here in the Life West Health Center, you will get to provide chiropractic care to individuals from our local community and see the benefits realized in the lives of those you interact with.

I can’t wait for you to see for yourself the joy that comes from helping others through chiropractic. During your internship you will get to work patients locally and many of you will get to participate in one of our many service opportunities. There is no greater reward to the culmination of your educational efforts than to see patients respond positively to care.

From me and all our faculty and staff, we hope you have a great clinical experience. Do not hesitate to reach out to faculty, staff, or me for anything you need as you progress through this exciting journey.

Yours in health,

Scott Donaldson, DC, EdD
Vice President of Clinical Operations
Life Chiropractic College West
Institutional Mission

To advance chiropractic through world-class chiropractic education, clinical excellence, philosophical inquiry, research and scholarly activity in a climate of love and service

Institutional Mission

To advance chiropractic through personalized learning, technique and pedagogic excellence, philosophical inquiry, entrepreneurial spirit and compassionate service

To lead chiropractic education with cultural authority in the profession, delivering the Doctor of Chiropractic program along with complementary master’s and doctorate programs

To transform humanity by our service while remaining grounded in the traditional philosophy and principles of chiropractic

To cultivate a college environment of innovation, collaboration, scholarship and research, and a commitment to give, do, love and serve from a place of abundance

Life West Health Center Purpose Statement

To prepare and train Life West Interns to be practice ready

To provide exceptional patient care and intern experience in an encouraging, supportive and inclusive environment
### Table of Contents

**SECTION ONE** ................................................................................................................................. 1

Health Center Organization .................................................................................................................. 2

Health Center Organizational Chart ..................................................................................................... 2

Health Center Intern Representative Committee .................................................................................. 2

Clinical Education and Competency ...................................................................................................... 3

Health Center Mentoring Program Information & Health Center Course Requirement ...................... 3

Health Center Graduation Requirements ............................................................................................... 4

Student Clinic 1: .................................................................................................................................. 4

Student Clinic 2: .................................................................................................................................. 4

Clinic 1: .................................................................................................................................................. 5

Clinic 2: .................................................................................................................................................. 6

Clinic 3: .................................................................................................................................................. 6

Clinic 4: .................................................................................................................................................. 7

Combination Registration Clinic 3 & 4: .................................................................................................... 8

Competency Examinations and Assessment Requirements ..................................................................... 9

COMPETENCY EXAMINATIONS: ............................................................................................................ 9

ENTRANCE EXAM (Two Part Examination—Written & Practical) ......................................................... 9

MID PROFICIENCY EXAM (Written Case Presentation & X-Ray Positioning) ........................................ 10

INTERN COMPETENCY EXAM (I.C.E.) .................................................................................................. 10

ASSESSMENTS (QUALITATIVE) REQUIREMENTS ............................................................................. 11

Table 1.................................................................................................................................................... 12

Quantitative Graduation Requirements ................................................................................................ 12

Adjunctive Therapy (Physiotherapy) ...................................................................................................... 13

Table 2.................................................................................................................................................... 13

FORMATIVE ASSESSMENT (Qualitative Requirements) ....................................................................... 13

Intern Assessments ............................................................................................................................... 14

CMR Assessment .................................................................................................................................. 14

Report Of Findings Assessment ............................................................................................................ 14

Patient Visit Assessment ...................................................................................................................... 14

Eligibility for Preceptorship Programs .................................................................................................. 15

UNDERGRADUATE PRECEPTORSHIP ............................................................................................... 15

POSTGRADUATE PRECEPTORSHIP .................................................................................................... 15

Eligibility For NBCE Licensing Examinations ....................................................................................... 16

Definition of Roles ............................................................................................................................... 16

PATIENT CATEGORIES ........................................................................................................................ 17

Clinical Competency Testing ................................................................................................................. 19
Trauma Patient Protocol (Personal Injury) ................................................................. 42

Personal Injury ........................................................................................................... 43

INITIAL PATIENT CARE ......................................................................................... 44
  Guide to Patient Diagnosis and Care Summary (PDCS) form ................................... 47

CASE MANAGEMENT REVIEW (CMR) PROCESS ............................................... 48
  Case Summary Narrative (Sample – on Canvas) ......................................................... 48
  Writing a Clinical Impression/Diagnosis ................................................................. 50

PROGNOSIS & GOALS ......................................................................................... 51

AUTHORIZED TECHNIQUES ....................................................................... 52

Ancillary Procedures (Physiotherapy) ................................................................. 52

REPORT OF FINDINGS ......................................................................................... 53

INFORMED CONSENT ....................................................................................... 55

Patient Visit Slip .......................................................................................................... 56

Office Visit/Adjustment Procedure ........................................................................... 56

EQUIPMENT (Sample – on Canvas) .................................................................... 57

RE-EVALUATION EXAM (Sample – on Canvas) .................................................... 57

Progress Re-evaluations (Sample – on Canvas) ...................................................... 57

Re-eval with New Complaint (Sample – on Canvas) .................................................. 57

In-activations ............................................................................................................... 58

CHANGE OF TECHNIQUE ................................................................................. 58

MEDICARE GUIDELINES (Sample – on Canvas) ....................................................... 58

PATIENT REFERRAL (Sample – on Canvas) ............................................................. 58

Clinical Laboratory Requests ..................................................................................... 59

OUTCOME ASSESSMENT TOOLS AND SCREENS (OATS) ................................ 60
  RAND-36 (Sample on Canvas) .................................................................................. 60
  General Instructions: .............................................................................................. 61

Contraindications/Red Dot Procedures .................................................................... 62

Examination: Gynecological/Proctological Exams .................................................. 62

PATIENT EDUCATION ......................................................................................... 62
OUTREACH .................................................................................................................. 63

Business Cards ........................................................................................................ 63

Advertising .................................................................................................................. 63

Social Media Advertising .......................................................................................... 64

INTERN SUBSTITUTION PROCEDURE ...................................................................... 65
One-Time-Only (OTO) Care .......................................................................................... 65
Vacation/Vacation Relief Process .................................................................................. 65
Co-Management ......................................................................................................... 66

Adjusting ...................................................................................................................... 67

WRITING IN THE PATIENT FILE .............................................................................. 67
S.O.A.P. Note Format Guidelines ................................................................................. 67

ABBREVIATIONS FOR HEALTH CENTER FILES (place this information in a table to clean it up) ...... 69

SECTION 3 .................................................................................................................. 74

Public Health Recommendations ................................................................................ 75

Crime Prevention ........................................................................................................ 75

Emergency Procedures .............................................................................................. 75

Personal Property ....................................................................................................... 76

Campus Law Enforcement .......................................................................................... 76

Equipment .................................................................................................................. 76

Abuse Reporting ........................................................................................................ 77
Child, Elder, or Dependent Adult Abuse - Reporting is Mandatory ................................. 77

Medicare Guidelines ................................................................................................. 77

Children ....................................................................................................................... 78

Communication Methods .......................................................................................... 78
   CANVAS .................................................................................................................. 78
   Email ......................................................................................................................... 78
   Calendar .................................................................................................................... 79

Visit Slip Procedures and Computer Functions .......................................................... 79

Community Benefits Program Procedures .................................................................. 79

HIPAA .......................................................................................................................... 80
   How is protection achieved? ..................................................................................... 80

vii
Personal Appearance and Dress Code................................................................. 82
Tobacco, Drug and Alcohol Use........................................................................... 84
Health Center ID ................................................................................................. 84
OSHA Standards................................................................................................. 84
Preceptorship Program......................................................................................... 84
Standard Process Procedures............................................................................. 85
Footlevelers ......................................................................................................... 86

SECTION 4 ........................................................................................................ 87
Health Center Manual......................................................................................... 87
Competency Assessment ..................................................................................... 88

SECTION 5 ........................................................................................................ 89
IMAGING POLICY ............................................................................................. 90
X-ray Appointment Sign up Procedure.............................................................. 92
Patient arrival and pre-radiographic preparation procedure ............................ 93
Post x-ray procedure.......................................................................................... 94

SECTION 6 ........................................................................................................ 98
Health Center Manual......................................................................................... 98
PATIENT BILL OF RIGHTS ............................................................................. 99
Patient Care Fee Schedule.................................................................................. 100
Laboratory: ......................................................................................................... 100
Rehab and Fitness............................................................................................... 100
X-Rays: See x-ray Fee Schedule: ....................................................................... 101

PRODUCTS FOR SALE IN THE HEALTH CENTER ...................................... 103
Health Center Protocol for Addressing Patient Inquiries and Concerns: ........... 105
Customer Service Inquiries or Concerns:.......................................................... 105
Patient Care Inquiries or Concerns: ................................................................... 105
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Patient</td>
<td>106</td>
</tr>
<tr>
<td>Medicare Patients</td>
<td>106</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>107</td>
</tr>
<tr>
<td>Health Center Fees for Students, Faculty, Staff, Faculty, Staff Family Patients</td>
<td>107</td>
</tr>
</tbody>
</table>
Health Center Manual

Section One

Health Center Organization

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center's policies and procedures as needed
**Health Center Organization**

The Vice President of Clinical Operations (VPCO) is the Chief Clinical Officer at Life West and reports directly to the president of the college. The VPCO has a cabinet known as the Health Center Administrative Group (HCAG) that consists of the following: the Dean of Clinical Competency, the Director of Compliance and Data Architecture, the Director of Imaging, and the Health Center Customer Service Manager. HCAG works together to ensure that policies and procedures are developed and managed to direct the Health Center functions so that the Health Center purposes are achieved. Below is an organizational chart indicating reporting structures for employees of the Health Center.

**Health Center Organizational Chart**

**Health Center Intern Representative Committee**

The membership of the Health Center Intern Representative Committee includes one representative of each of the Mentor's practice groups, a representative of each of the student clinic classes, a member of the student council, Health Center Administrators, and the Director of Student Life. The committee's functions include:

- Suggesting and implementing needed changes in policy or procedures
- Communication and information exchange between the Health Center Administration and interns
- Providing an affirmative environment for the airing of intern concerns
- Holding regular meetings

Students are encouraged to submit suggestions and/or concerns to their Practice Group or class
representative at any time and may be asked to personally appear before the committee at the discretion of the Vice President of Clinical Operations. Minutes of the Health Center Committee meetings are publicly communicated by the student intern representative as well as on the Intern Canvas Page and may be reviewed upon request to the Executive Assistant to the Vice President of Clinical Operations.

Clinical Education and Competency

The Health Center experience is a combination of the following components, including:

1. Classes: Student Clinic/Clinical Learning Lab Experience, Clinic Classes during the outpatient experience.
2. Assessments (each is described in detail later in this document):
   - Examinations: Entrance, Mid Proficiency, and Intern Competency (I.C.E.)
   - Case Management Review (CMR)
   - Report of Findings (ROF)
   - Patient Visit Encounter (PVE)
3. Hours: 518 clinical hours
4. Patient Care: guideline for completion of this requirement is in the Graduation Requirements
5. Outreach: Students are required to complete two (2) community outreach credits.
6. Participation in a practice Mentoring groups

Any interruption in Health Center activity such as results from suspension or voluntary leave that is greater than 10 weeks will require a repeat of the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. An interruption in Health Center activity that is 6 months or greater will require a repeat of the Student Clinic 1 course, the written Health Center Entrance Exam, and the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. Activity that is less than minimum (3 patient care activities per week) for 6 months or more will require a repeat of the Health Center Entrance Practical Exam.

Health Center Mentoring Program Information & Health Center Course Requirement

1. Syllabi are provided for each course and competency examination and include both
specific course requirements and description.

2. School policies regarding tardiness and absences apply to SC1 and SC2 classes. Additionally, mentor group participation is outlined in the Mentor Group Attendance Requirement.

3. If a student fails to complete HC course requirements, the course must be retaken in the following term (students will stay with their assigned mentor until graduation). Failure to proceed through the Health Center in the prescribed timely manner will delay anticipated graduation dates.

4. Requirements for clinic course work must be met by Friday of the 1st week of the following quarter in order to change a grade from INC to PASS; otherwise, the grade will be changed to a NO PASS by the beginning of Week 2 with registration and finalized into CAMS by Week 3.

   A student must be registered in a clinic class in order to engage in any patient related activities in the Health Center.

**Health Center Graduation Requirements**

The following are Life Chiropractic College West Health Center graduation and progression requirements. These are the minimum requirements to progress from one quarter to the next and to graduate. Interns are strongly urged to set goals higher than the minimum requirements.

*Course Requirements, Competency Examinations & Graduation Requirements*

Quick Reference Guide

**Student Clinic 1:**
- Pass *Entrance Written* (75% or better)
- Intern served as a Mock patient for both Entrance Practical/Entrance Practical Remake
- Pass HIPAA Compliance test
- Hours in HC = 10
- Complete Reciprocal Initial Care Plan

**Student Clinic 2:**
- Pass Entrance Practical & X-Ray Exam
- Ten Assessed PVE in the Student Health Center
- Hours in the HC = 30 *(40 total)*
- CMR completed & assessed for reciprocal patient
- At least one ROF as a result of any examination must be assessed by HC faculty
- Required attendance HC Recognition Seminar (end of quarter)
- Outpatient care begins once you are assigned to a Practice Group AND have completed 20 student adjustments  (Note: Students with less than 10 student adjustments by end
of week 5 will meet with their new Mentor by end of week 7)

ASSSESSMENT REQUIREMENTS:

* 1 CMR completed & assessed by HC faculty for reciprocal patient
* 1 ROF as a result of any examination are to be assessed by HC faculty
* 10 PVEs Assessed total which may include assessed accumulated from your SC-1 quarter
* NOTE: Total assessment requirements are described under clinic four, but are cumulative. Once the intern has achieved required competencies for any assessment, they have met the requirement and do not need to continue additional assessments with that tool if they are ready to participate in the preceptor program.

Clinic 1:

- 20 student category patient adjustments must be completed prior to beginning outpatient care
- Outpatient adjustments = 30 adjustments to be on track to finish within four quarters (required to qualify for Mid Proficiency examination in clinic two)
- Complete one CMR on a patient that has had at least an initial exam, some care and a re-evaluation
- At least one ROF as a result of any examination is to be assessed by HC faculty
- Hours in HC = 120 (160 total)
- Patient encounters assessed by HC faculty - At least 5 outpatient visits assessed by a faculty member (ideal to complete one per week for first five weeks, ten total qualifying as competent in two consecutive quarters to graduate)
- Attendance at required Advisor meetings (LCCW attendance rules apply i.e. >10% = an overcut)

ASSSESSMENT REQUIREMENTS:

* 1 CMR completed & assessed by HC faculty (Must have two at competent to graduate)
* 1 ROF as a result of any examination is to be assessed by HC faculty (CUMMULATIVE TOTAL = 2)
* 5 PVEs Assessed total (cumulative total is 15)
* NOTE: Total assessment requirements are described under clinic four, but are cumulative. Once the intern has achieved required competencies for any assessment, they have met the requirement and do not need to continue additional assessments with that tool if they are ready to participate in the preceptor program.
Clinic 2:

- Pass *Mid Proficiency Examination*
- Outpatient adjustments = 60 adjustments to be on track to finish within four quarters (required by end of Clinic 2 to qualify for ICE in Clinic 3)
- Complete one CMR on a patient that has had at least an initial exam, some care and a re-evaluation
- At least two ROFs as a result of any examination are to be assessed by HC faculty (two qualifying as competent during clinic two is the target, *five total qualifying as competent to graduate*)
- Hours in HC = 120 (**280 total**)  
  - Patient encounters & assessed HC faculty - At least 5 outpatient visits assessed by the mentor (ideal to complete one per week for first five weeks, *ten total qualifying as competent to graduate*)
- Attendance at required Advisor meetings (LCCW attendance rules apply i.e. >10% = an overcut

- **ASSESSMENT REQUIREMENTS:**
  - 1 CMR completed & assessed by HC faculty (Must have two at competent to graduate)
  - 2 ROFs as a result of any examination are to be assessed by HC faculty
  - 5 PVEs Assessed (Cumulative total is 20)
  - *NOTE: Total assessment requirements are described under clinic four, but are cumulative. Once the intern has achieved required competencies for any assessment, they have met the requirement and do not need to continue additional assessments with that tool if they are ready to participate in the preceptor program.*

Clinic 3:

- Must pass ICE to pass Clinic 3 & before checking out of HC
- 120 hours in HC (**400 total**)  
  - At least 110 outpatient adjustments to be on track to finish within four quarters
  - 16 total patient (8 outpatient) to be on track to finish within four quarters
  - Complete one CMR on a patient that has had at least an initial exam, some care and a re-evaluation
  - 2 Assessed ROF/Informed Consents with competent or proficient scoring (qualifying as competent; defined as 3 or 4 out of 4 on all sections of the ROF/Informed Consent rubric. *five total qualifying as competent to graduate*)
  - 5 Assessed patient Encounters with competent or proficient scoring (defined as 3 or 4 out
of 4 on all sections of the Patient Visit Encounter rubric. ten total qualifying as competent to graduate

- Attendance at required Advisor meetings (LCCW attendance rules apply i.e. >10% = an overcut)

**ASSSESSMENT REQUIREMENTS:**

* 1 CMR completed & assessed by HC faculty (Must have two at competent to graduate, once two are completed as competent the intern does not need repeat this assignment)
* 2 ROFs as a result of any examination are to be assessed by HC faculty
* 5 PVEs Assessed (Cumulative total is 25)

*NOTE: Total assessment requirements are described under clinic four, but are cumulative. Once the intern has achieved required competencies for any assessment, they have met the requirement and do not need to continue additional assessments with that tool if they are ready to participate in the preceptor program.*

**Clinic 4:**

- 120 hours in HC (518 total)
- 250 total and 200 outpatient adjustments
- 20 total patient (16 must be outpatient) files through Care & Management Plan Review (completed & assessed)
- Collaborative Care Letter with Grade of 75% or better (DIAG 416-NMS Diagnoses and Management)
- Attendance at required Advisor meetings (LCCW attendance rules apply i.e. >10% = an overcut)
- All other graduation requirements must be met in order to pass Clinic 4. Refer to Graduation Requirements included in this document listed below.

*NOTE: You must remain ‘Active’ in patient care until such time as all coursework is completed i.e. you may not check out of the HC until your coursework is complete. Refer to the HC Policy & Procedures Manual for the LCCW definition of ‘Active’.*

- Active patient care must be maintained through to Week 8 of the quarter
- Quality Assurance Audits have been appropriately remediated and do not remain outstanding. (This includes HIPAA, ethical or legal issues, accuracy of documentations, diagnosis, billing etc.)
• **ASSESSMENT REQUIREMENTS:**

* Must have a total of at least two CMR assessments in two distinct quarters at a qualifying level
* Must have a total of at least five ROF assessments at a qualifying level
* Must have a total of at least ten PVE assessments at a qualifying level
* NOTE: Qualifying = Competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the assessment rubrics)
* NOTE: Once an intern has achieved minimal qualifying requirements for the above rubrics, the requirement has been met.

* NOTE: Classes **highlighted** may be taken concurrently by petition. Passing ICE is a requirement for passing Clinic III.

**Combination Registration Clinic 3 & 4:**

- To qualify to take Clinic 3 & 4 together by Week 10 of the quarter preceding the following must be completed:
  - 85 Outpatient adjustments
  - 16 total patients (8 must be Outpatient) files approved through PDCS (completed & assessed)
  - 120 hours in the HC (400 total)
- Pass *Mid Proficiency examination*
- Must be in the final quarter of academic classes
- Must have completed no less than 4 quarters of HC coursework including Student Clinic 2 (SC-2) coursework AND be on track in accordance to the track you have chosen i.e. you are enrolled in 11Q of your 12Q program OR 13Q of your 14Q program.

NOTE: Clinic 3 and 4 are not taken together to qualify for preceptor. Pre-graduate preceptorship are done concurrent with the final clinic courses.

**Directed Study (1 Credit):**

- Clinic 4 completed
  Active patient care must be maintained through to Week 8 of the quarter
Competency Examinations and Assessment Requirements

COMPETENCY EXAMINATIONS:

A degree audit will be performed prior to the release of the grades for each of the competency examinations to ensure that each student was eligible to participate. The Dean of Clinical Competency reserves the right to withhold the release of a grade.

ENTRANCE EXAM (Two Part Examination—Written & Practical)

Coursework Prerequisites:
- TECH 116  Palpation I
- TECH 124  Diversified Analysis
- TECH 129  Motion Palpation
- TECH 130  Diversified Technique I
- TECH 216  Biomechanics of the Spine
- TECH 211  Gonstead A
- PATH 315  Bone and Joint Path
- DIAG 239  Spinal Ortho Exam
- TECH 222  Gonstead B
- DIAG 226  Case History
- DIAG 237/737  Neuro Exam Lecture/Lab
- DIAG 236  Exam: Thorax/Abdomen
- DIAG 327  Biomechanics of the Extremities
- ACS 313/813  Radiology I Lecture/Lab
- **ACS 322/822  Active Care and Rehab Lecture/Lab**
- TECH 238  Diversified Technique II
- **ACS 232  Emergency Care**
- DIAG 316/816  EENT Lecture/Lab
- DIAG 317  Correlative Diagnostic Procedures
- **ACS 335  Radiology II**
- ACS 311/811  PT Modalities Lecture/Lab
- TECH 233  Toggle
- TECH 325  Integrated Drop-Table Technique
- HC 310  Student Clinic I
- CPP 318  Patient Education Systems

NOTE:

Classes highlighted may be taken concurrently by petition. Passing the Entrance Practical is a requirement for passing Student Clinic II.

A student may be deficient in no more than 20 units total. No more than one technique class may be missing.

Student Clinic I & Correlative Diagnostic Procedures must be taken the quarter immediately preceding the Student Clinic II class.

Curriculum changes to Extremity Adjusting, Extremity Management as well as the Active and Passive Care coursework will impact the content of our Competency Examinations. It is expected that there will be changes to the prerequisites as the new curriculum is fully implemented by January 2018.

The Exam Specifics:

1. Written Exam
   - Serves as the final exam for the Student Clinic 1 course
   - Must pass with 75% or better
2. Practical Exam (including X-Ray Exam)
   - Pass Entrance Written Exam
   - Must be in Student Clinic 2
   - All academic coursework through Junior 1 level completed
MID PROFICIENCY EXAM (Written Case Presentation & X-Ray Positioning)

Coursework Prerequisites:
- DIAG 340 Neurodiagnosis
- ACS 345 Clinical Laboratory Diagnosis A
- ACS 312 Radiographic Positioning
- HC 332 Clinic I
- HC 501 Entrance Exam
- ACS 320 Applied Nutrition
- ACS 346 Clinical Laboratory Diagnosis B
- DIAG 408 Differential Diagnosis A
- TECH 336 Extremity Adjusting
- TECH 339 Extremity Soft Tissue Management

The Exam Specifics:
- Must be registered in Clinic 2
- Must have served as a mock patient for the I.C.E. Exam in the same quarter you are taking Mid Proficiency examination (If you are repeating Clinic 2 and/or Mids for any reason, you must be a patient again)
- Minimum 30 outpatient adjustments by the end of Clinic 1
- Management of minimum of 5 patients (2 of which must be outpatient). Patient Management is monitored and overseen by the Mentor in charge of the patient file.
- All academic coursework through Junior 3 level completed

INTERN COMPETENCY EXAM (I.C.E.)

Coursework Pre-requisites:
- DIAG 420 GI-GU Diagnosis
- DIAG 323 Obstetrics
- ACS 324 Radiology III
- DIAG 412 CV Pulmonary Diagnosis
- DIAG 426 Pediatrics
- DIAG 416 NMS Diagnosis and Management
- DIAG 415 Geriatrics
- DIAG 331 Psychiatry
- ACS 208 Radiology Review
- HC 413 Clinic II
- HC 502 Mid-Proficiency Exam

NOTE:
Classes highlighted may be taken concurrently by petition.

PASSING MIDS IS A REQUIREMENT FOR PASSING CLINIC II.

CURRICULUM CHANGES TO EXTREMIT Y ADJUSTING, EXTREMIT Y MANAGEMENT AS WELL AS THE ACTIVE AND PASSIVE CARE COURSEWORK WILL IMPACT THE CONTENT OF OUR COMPETENCY EXAMINATIONS. IT IS EXPECTED THAT THERE WILL BE CHANGES TO THE PREREQUISITES AS THE NEW CURRICULUM IS IMPLEMENTED.

NOTE:
Classes highlighted may be taken concurrently by petition.

PASSING ICE IS A REQUIREMENT FOR PASSING CLINIC III.
- Intern must have passed *Mid Proficiency examination* and Clinic 2 in order to take *I.C.E.*
- Must pass I.C.E. to pass Clinic 3
  - Not allowed to check out of HC or participate in Preceptorship Program unless passed I.C.E.
- Outpatient adjustments = 70
- Management of 10 patients total and 5 outpatient files by the end of Clinic 2 to qualify to take I.C.E. in Clinic 3
- In the case of Incomplete grades for Clinic 2 resulting in a No Pass or other grade disputes, students will not be released grade for I.C.E Exam and will be required to retake I.C.E the following quarter when eligible.

**NOTE:** Classes highlighted may be taken concurrently by petition. Passing ICE is a requirement for passing Clinic III.

**ASSESSMENTS (QUALITATIVE) REQUIREMENTS**

**NMS Referral Letter** Grade of 75% or better (DIAG 416-NMS Diagnosis and Management)

It is important to note that not all requirements for graduation will be met in your Clinic 1-4 classes. If you were a transfer student or changed the pace of your program during either your academic coursework or the Health Center it is your responsibility to ensure that you understand where you stand in the lead up to graduation AND that you confirm the qualitative assessment requirements with the Dean of Clinical Competency. Please consult ourClinical Education Coordinator, Yeissel Aguilar, with any questions.

**Case Management Review (CMR):** Assessment of the intern’s clinic reasoning abilities is demonstrated through the CMR process and assessment with scores that show progression of understanding throughout the internship. CMR includes a narrative and comprehensive review of a selection of the intern’s cases until the minimum competency is achieved. Details are described later in this document.

**Report of Findings (ROF):** Interns are required to demonstrate that they can communicate information to the patient by completing a formal Report of Findings (ROF) with the patient following each examination. The intern will be assessed during the ROF by their mentor each quarter enrolled in the Health Center.

**Patient Visit Encounter: (PVE):** The patient visit encounter is one of the most important events to demonstrate competence in patient care, communication and professionalism. Interns will be assessed multiple times during each quarter they are enrolled.

To demonstrate **competence** or to **qualify** the intern must achieve a score of 3 or 4 in each of the domains assessed on the any of the rubrics (CMR, ROF, or PVE) utilized during the
internship. If the assessment score is less than 3, the faculty member will include comments to inform the area/s of needed improvement. See requirements under clinic four needed to achieve and demonstrate competence in all required areas.

**GRADUATION REQUIREMENTS**

Table 1  
Quantitative Graduation Requirements

<table>
<thead>
<tr>
<th>Hours in the Health Center</th>
<th>Total hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Adjustments</strong></td>
<td>200</td>
</tr>
<tr>
<td>Note: Up to 50 adjustments total may be completed during a service trip, as a participant in MTA or during a preceptorship (adjustments may be completed as part of a preceptorship starting in the fall 2019). Office Visits w/o adjustment will not count toward this number. At total of 250 patient visits (combination of outpatient and student patients) are required.</td>
<td></td>
</tr>
<tr>
<td><strong>Student Adjustments</strong></td>
<td>50</td>
</tr>
<tr>
<td>10 student patient encounters must be assessed. At least 20 student patient visits are required to qualify for outpatient care. 50 student patient visits are not required, but up to 50 student patients can count toward the total of 250 patient visits required.</td>
<td></td>
</tr>
<tr>
<td><strong>Adjunctive Therapy/Physiotherapy</strong></td>
<td>30*</td>
</tr>
<tr>
<td>* This number varies per state; ensure that you know what is required of you if you are planning on practicing outside of the state of California i.e. this is NOT an LCCW graduation requirement.</td>
<td></td>
</tr>
<tr>
<td><strong>Radiology (X-ray)</strong></td>
<td>30</td>
</tr>
<tr>
<td>Interpretation of 30 studies of which 15 Radiology Case of the Week with a passing score, are required.</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Cases</strong></td>
<td>20</td>
</tr>
<tr>
<td>Up to 4 may be student patients 3 may be paper based cases assigned by the Competency Department in the intern’s final quarter 13 must be outpatients (4 of these may be courtesy patients)</td>
<td></td>
</tr>
<tr>
<td>• 5 of 13 must be new to the Health Center (to qualify will include an initial care plan, five visits and a re-evaluation)</td>
<td></td>
</tr>
<tr>
<td>• 8 additional patients may be transfer or new (also include and initial or transfer care plan, at least five visits and a re-evaluation)</td>
<td></td>
</tr>
</tbody>
</table>
| • Inclusion of the 13 cases that can be considered managed by the intern is up to
Adjunctive Therapy (Physiotherapy)

The California Board of Chiropractic Examiners requires the application of 30 physiotherapy modalities while enrolled in Chiropractic College, which includes any of the physiotherapy modalities taught at LCCW.

This is State requirement, not an LCCW graduation requirement. It is strongly advised that students personally obtain information on the educational and licensure requirements of the states or regions in which they may wish to practice. The Learning Resource Center at LCCW maintains a file of individual state requirements for consultation.

Table 2
FORMATIVE ASSESSMENT (Qualitative Requirements)

<table>
<thead>
<tr>
<th>Type</th>
<th>SC-1/SC-2</th>
<th>C-1</th>
<th>C-2</th>
<th>C-3</th>
<th>C-4 (# Qualifying Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMR</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ROF</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>PVE</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

NEW THRESHOLDS begin WINTER 2018 for ALL INTERNS moving forward.

Through the process of assessment continued throughout the intern experience, demonstrating continued progress and achievement of competence LCCW ensures that all interns graduate having met all CCE required meta-competency outcomes. A copy of the meta-competency outcomes and their alignment to the tools and measures as described in this document is available from the Health Center administration. The required meta-competencies and their associated outcomes are also available on the CCE website.
Students are required to meet all quantitative and qualitative requirements in order to graduate. Students who do not meet all requirements by the end of the 4th outpatient quarter, will be required to register for an additional quarter and remain in practice under the direction of the practice mentor until all requirements have been met. Interns have a maximum of ten academic quarters (from the time outpatient care begins) to complete all requirements.

**Intern Assessments**

**CMR Assessment**
The CMR assessment will be completed by the CMR (Floor) faculty. The CMR assessment serves to identify the strengths and weaknesses of the intern with regard to his/her ability to formulate an appropriate clinical impression and care plan. All CMR assessments will be maintained as part of the intern’s mentor records and will be used to assess the interns’ progress. Interns will complete a narrative and schedule a CMR for one file each quarter beginning with Student Clinic 2. The file to be considered will be chosen by agreement with the intern and the mentor faculty. Once a file has been presented at CMR, it cannot be used again for this purpose. The intern will present each quarter until they have achieved qualifying competence on two separate files. If the CMR assessment is not qualifying, the intern can utilize the feedback provided to improve the file and narrative and present the case a second time in the same quarter and be re-assessed. Re-assessment is limited to once per quarter and file. **Requirement: Two (2) Qualifying CMR Assessments**

**Report Of Findings Assessment**
All Report of Findings are assessed by a Health Center Faculty. The Informed Consent is part of the Report of Findings (ROF). Minimum requirements for total number of assessments of ROF are described above. Interns will complete assessments for ROF until the minimum number of qualifying assessments has been achieved. **Requirement: Five (5) Qualifying ROF Assessments**

**Patient Visit Assessment**
Each intern-patient care contact is considered an important competency element in the education of the intern. The observer, therefore, may document or otherwise report his/her findings as part of the competency record of the intern. All patient visit assessment forms will be maintained as part of the intern’s mentor records and will be used to assess progression. Minimum requirements for total number of assessments of PVE are described above. Interns will complete assessments for PVE until the minimum number of qualifying assessments has been achieved. **Requirement: Ten (10) Qualifying PVE Assessments**

**Grading Criteria for Patient Visit Evaluations**
The following criteria are to be used to grade patient visit evaluations. These criteria will be used for all interns and for all observed patient visits, except for OTOs. Please use the additional comment section of the evaluation form if necessary.
Professional Component
Interns will receive a score between 1-4 for professionalism. Faculty will take into account the following components and will give one average score.

Records Component
Interns will receive a score between 1-4 for records. Faculty will take into account the following components and will give one average score.

Adjusting Skills Component:
Interns will receive a score between 1-4 for adjustment skills. The intern will be given separate grades for each region of the spine adjusted that visit. Faculty will take into account the following components and will give an average score for each region.

Intern Assessment Feedback
Interns will meet with their mentors periodically to review their performance and progression through the program. Mentors review the following feedback reports with interns: ROF Feedback report, PVE Feedback, CMR Feedback.

Eligibility for Preceptorship Programs

UNDERGRADUATE PRECEPTORSHIP

- Completed all Qualitative requirements to graduate
- Completed all quantitative requirements to graduate with the exception of hours
- All course work that is not offered online must be completed
- All competency exams passed.
- Earliest possible date of departure is Week 8 of the quarter the intern is completing their work.
- Intern MAY continue to see patients in the Health Center while participating in the Undergraduate Preceptorship Program.

POSTGRADUATE PRECEPTORSHIP

- Can begin as early as Week 8 of the graduation quarter providing the graduate is met ALL college requirements for graduation and has checked out of the Health Center with the Health Center Registrar.
Eligibility For NBCE Licensing Examinations

NBCE Exam Requirements.

Part I – Must have passed all Basic Sciences classes through Sophomore C/2 at time of application. The student can be missing one Basic Science class, excluding Science Review.

PT – Must have passed PT I, PT II with final grades posted prior to submitting an application for this exam.

Part II – At the time of the application, the student must be completing all Jr 3 courses and be concurrently enrolled in Sr 1 in the quarter of the exam. The student can be missing 1 course through Jr 3 or be above a CUM GPA of 3.0. At the time of submitting the application, students are to be enrolled in Clinic I, have completed 1 outpatient file and 20 outpatient adjustments. A student can apply while completing the Jr 3 courses providing they have completed the Health Center requirements listed above.

Part III – Students must be within nine (9) months of graduation when taking part III (enrolled in clinic 2 or later) and have successfully completed part I of the NBCE exams to qualify.

Part IV – Students must be within six (6) months of graduation when taking part IV (enrolled in clinic 3 or later) and have successfully completed part I of the NBCE exams to qualify.

NOTE: In the case of ‘Incomplete’ grades or grade disputes, students may have to file after the preferred application deadline. In this case, the student may be approved for the next NBCE offering

Your Contacts & Their Role:

Dr. Scott Donaldson – Vice President of Clinical Operations
Dr. Bruce Chester – Dean of Clinical Competency, Chair of the Clinical Standard Committee
Ryan Odell – Director of Health Center Compliance and Data Architecture
Amiee Fiorito – Executive Assistant to the VPCO (Outreach & Preceptorship Coordinator)
Yeissel Aguilar – Clinical Competency Coordinator
Judy Lum – Health Center Registrar
Dr. Jenifer Warnock – Health Center, Director of Imaging
Maria Lopez – College Registrar & Graduation Eligibility/ Intent to Walk Contact
Andrew Herrera – Health Center Customer Service Manager

Definition of Roles

Health Center Faculty Doctors fulfill several roles for interns in the Health Center, and their purpose is to assist interns in the practical clinical applications of the skills they have learned to date as they transition from students of the science, philosophy and art of chiropractic to a practitioner preparing to join the profession upon graduation.
Mentor Doctors – These doctors lead a group of interns in smaller practice groups in order to help develop their case management and adjusting skills. They are available to discuss and advise on patient cases, advice on marketing opportunities, to review patient files, and as a reference for college policies and procedures. When an intern is assigned to a Mentor Group or practice, he/she is required to attend weekly practice meetings, and the Mentor is his/her point person for any issues relating to his/her time in the Health Center.

A Student Clinic 2 intern is assigned to a practice group and Mentor at the quarterly draft at which interns make their preferences known, and the Mentor doctors make their selections based on many factors relative to the needs of the practice. Interns are practicing under the license of their Mentor doctor, and are responsible for the patient care by his/her interns.

Health Center Floor Faculty Doctors – These doctors serve additional roles within the Health Center. Interns have the opportunity to learn from these doctors in the Radiology department where they will learn how to take radiological images as well as to effectively communicate with patients, increasing the patient's confidence in their intern. Interns participate in guiding their patients through the x-ray process in order to gain the appropriate images necessary for their chiropractic care.

Additionally, these doctors conduct Case Management Reviews (CMRs) where the interns’ diagnosis, management plan and prognosis and goals of care for their patients are reviewed, discussed, and assessed. Over time, this helps the interns to create thoughtful, intelligent and detailed management plans for their patients.

Finally, these doctors also oversee direct patient care in the Student & Outpatient Health Center as interns deliver patient Report of Findings, review the informed consent form, and deliver chiropractic adjustments and related care. Whether in the Student Health Center or in the Outpatient Health Center, patient interactions are routinely observed and assessed by Health Center faculty who are available to assist with care as needed, make appropriate recommendations and review interns’ patient records for accuracy and completion.

PATIENT CATEGORIES

Patients fall into three categories with regard to payment, standard patients, courtesy patients, and discounted services patients.

Courtesy Patients

Courtesy patients include the following sub-categories:

Student Patient Credit:
- All students enrolled at LCCW (file numbers beginning with 7 and ending in A)
Includes Alumni up to two years from their graduation date

All Student patients pay for lab work and supplies such as cervical collars, heel lifts, etc. (Exception: LCCW students can receive two pairs of Foot Levelers for free while enrolled at LCCW).

**Outpatient Credit Courtesy:**
- LCCW student family (spouse, partners, and dependent children age 17 or younger)
  - All LCCW students are allowed to designate two (2) other courtesy category patients associated with the student’s file number while enrolled.
  - Patients in this category are not counted as “new patients” toward graduation requirements.
- Faculty and Staff of LCCW and their immediate families (spouse, partners, and dependent children age 17 or younger)
  - Community Benefits patients
  - LCCW Alumni after 2 years from their graduation date
  - LCCW non-student athletes (includes community players, but not their families)
  - LCCW Café Employees (but not their family members)

**All Outpatient Credit Courtesy** patients pay for lab work and supplies such as cervical collars, heel lifts, Foot Levelers, etc. (Exception: LCCW faculty and staff can receive a pair of Foot Levelers every other year).

**NOTE:**
- Interns are limited to four Outpatient Credit Courtesy patients for credit during their internship and all four may be active concurrently.
- SC2 can start seeing all outpatient categories when they have completed all parts of the entrance examination and 20 student patient visits.

*NOTE THE FOLLOWING CLARIFICATIONS:*
- Must designate category during New Patient file activation.
- No change in patient category until the intern initially assigned graduates or if patient turns 65 and becomes a Medicare Patient.

**Discounted Categories**

**The following receive 50% off all services:**
- Military members active or veterans and their immediate family members
- Civil Servants to include, Police, fire fighters, EMTs
- Current full-time college or university students
  - If the spouse or partner of a patient begins care, the office visit is $22
  - Minor children of patient’s under care receive 50% off office visits
Standard Fee Patients

All who do not fall into one of the above categories is considered a standard fee patient. Special consideration must also be given to the management of Medicare patients.

Clinical Competency Testing

1. Under normal circumstances, the Practical Entrance Exam and the exit Intern Competency Exam (I.C.E.) area administered during the first week of the quarter. The Mid Proficiency exam is administered during the 6th week of the quarter. The students are provided information about each examination in advance of the testing date(s).

2. All clinical tests must be taken in sequence during the scheduled dates of examination in each quarter, and may not be taken concurrently with one another.

3. Each test is comprised of one or more component subject areas including: diagnostic skills, technique, x-ray, physiotherapy and some patient education. Achievement of a score of 75% or more is required to pass any test component. Under normal circumstances, grades will be reported to the student and remake examinations are then scheduled as needed.

4. Appeals following test failure are not possible until after the remake examination has been taken.

5. In a remake situation, whenever possible, the examiner who tested the student in the initial examination will not test the student again.

6. College policy for fees applies for a clinical remake examination. A remake is defined as 1 or more components of the original exam.

7. Failure of a clinical examination (the test and its remake) two times will result in a summative evaluation and academic notice.

8. If the student receives a “No Pass” then the entire examination must be retaken the following quarter.

9. Entrance Examination: Interns can see their reciprocal as assigned in the Correlative Diagnostic Exam Procedure class. Once the Written examination is passed, the intern can also see other enrolled students. Upon passing the Practical Entrance exam, the intern can see any patient in the student category (including student family and student courtesy patients).

10. Mid Proficiency Examination: Passing the Mid Proficiency exam is required to pass Clinic II and to qualify for I.C.E.

11. Interns must pass I.C.E. in order to pass Clinic III

12. Intern Competency Exam (I.C.E.): the student must pass all components of I.C.E. as a requirement for graduation
Clinic Examination Description and Requirements

Entrance Examination 501: 1 unit
Test Goal: The entering intern should display entry level competency in eliciting information from the history, physical examination, x-ray studies, and spinal exam stations. They must also be able to demonstrate basic psychomotor skills in the physical examination, physical therapy modalities, and in the four technique stations. Candidates should show the ability to recognize when presenting conditions fall outside of normal and interpret those findings to arrive at working conclusions. They must also show the professionalism to be able to perform the above in a stressful environment.

The Entrance Examination consists of:
1. Written Exam
2. Practical Exam

Includes a 25-station multiple choice X-ray reading exam. The Written exam is 100 questions in a multiple-choice format. The candidate is also responsible for X-ray markings taught in core technique classes and for CMR required lines of mensuration as shown in the Health Center Manual. The candidate is not required to bring x-ray marking tools. Questions will include material on technique, diagnosis, x-ray, physiotherapy and the Health Center Policies and Procedures. This examination also serves as the final examination for the Student Clinic 1 course.

• If a student fails the Written Entrance exam and its remake, she/he will be required to retake Student Clinic 1 class and retake the examination the following quarter.
• Passing of the Written exam is required for the intern to proceed to the additional portions of the exam.

The Practical portion of the exam is designed to test the candidate’s ability to think critically, verbalize, and demonstrate their knowledge in technique, diagnosis and patient education (see Entrance Exam material distributed in Student Clinic 1 class). The practical portion of the exam is given in week one of the Student Clinic 2 quarter.
• The practical exam includes a 25-station multiple choice x-ray reading exam.
• The multiple-choice x-ray reading exam includes normal skeletal anatomy and variants, congenital anomalies, trauma, and arthritis.
• All academic course work, through Junior 1 level, is required to take the Entrance Practical. See Section 1.
• If a student fails the Practical Entrance exam and its remake, he/she will be required to retake the Student Clinic 2 class and repeat the Practical examination the following quarter.
Students must be enrolled in a clinic class in order to provide any patient care.

Any interruption in Health Center activity such as results from suspension or voluntary leave that is greater than 10 weeks will require a repeat of the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. An interruption in Health Center activity that is 6 months or greater will require a repeat of the Correlative Diagnostic Exam Procedures course, Student Clinic 1, the written Health Center Entrance Exam, and the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. Activity that is less than minimum (3 patient care activities per week) for 6 months or more will require a repeat of the Health Center Entrance

Practical Examination

Mid Proficiency Exam: 502: 1 unit

Test Goal: The intern must demonstrate the ability to interpret, synthesize and apply appropriate critical thinking skills in the development of a management plan for a given case. This must include: a working diagnosis and differentials, a realistic care plan including any additional tests, lab and x-ray assessment, appropriate referrals and a functional and structural prognosis. The Mid Proficiency exam is given to determine clinical progress and identify areas of weakness or deficiency.

The following is required to take the Mid Proficiency Exam:

1. All academic course work through the Junior 3 level.

2. The student must participate as a mock patient for I.C.E. in Clinic 2 and each subsequent quarter until the Mid Proficiency Exam is passed.

3. 30 outpatient adjustments by the end of Clinic 1

4. The student must have managed at least 5 files, 2 of which MUST be outpatient.

5. The test is normally taken during the 6th week of the Clinic 2 quarter and an intern is considered to be progressing normally if they qualify to take it then. The test may be taken during the Clinic 1 quarter if the intern has otherwise qualified, including coursework.

Mid Proficiency Exams consist of:

1. Written Case Presentation

2. X-ray positioning

For the Case Presentation the intern is given a simulated patient file. The intern is expected to write a presentation similar to a case summary narrative. The presentation will include a complete diagnosis, 2 differential diagnoses, a plan of care, prognosis, and discussion of x-ray positioning.
ray and lab findings. The intern is required to know the correct x-ray positioning for a Basic 7 series and will be expected to demonstrate and explain this information.

Should an intern fail to successfully pass the Mid Proficiency exam and remake, he/she will receive a “No Pass” for the exam and will have to retake those parts failed the following quarter. The student will also receive a No Pass for Clinic II.

**Intern Competency Examination (I.C.E.) Also Known As Exit Examination:**

**503-01: 1 Unit**

Test Goal: The candidate must display exit level competency on a multi-station simulated patient exam consisting of comprehensive analysis, case management, co-management, or referral, if necessary, and demonstrate patient examination and adjusting skills. The exam will include the following:

1. Diagnosis and Case Management
2. Chiropractic Technique
3. X-ray interpretation

**The following is required to take the I.C.E. test:**

1. Intern must have passed the Mid Proficiency Exam in a previous quarter
2. Intern must have completed 70 outpatient adjustments and have managed a total of 10 patient files (at least 5 of which must be outpatient files) by the end of Clinic II
3. See the college website for specific course requirements:
4. Should an intern fail to successfully pass the I.C.E. exam and remake, he/she will receive a “No Pass” for the exam and will have to retake those parts failed the following quarter. The student will also receive a No Pass for Clinic III.

Interns are not allowed to check out of the Health Center or participate in the Preceptorship Program unless they have passed I.C.E.

**Intern Hours**

California law for chiropractic students requires 518 clinical hours. Required Health Center hours are recorded by means of a check in/out procedure.

- At the Records Room, you must check in and out, in clinic attire.
- If you are checked in, you must be on the Health Center premises and be available for patient care.
- Failure to check out prior to leaving the Health Center will result in zero hours for the day.
- Interns may not be clocked in when they are supposed to be in class or when performing work study job duties.
Health Center Disciplinary Actions

When the College determines the need to address behavioral or performance matters within its own structure, the policies and procedures in the Disciplinary Policies and Procedures Manual will be followed.

I. Administrative Intervention

When circumstances exist in which the safety and/or welfare of the college community is jeopardized by the action(s) of one or more students, the College retains the right to intervene, taking immediate administrative action.

II. Conflict Resolution

The College attempts to resolve complaints concerning violations of policy or conduct through the Health Center Administration/Conflict Resolution Officer or Life West (CRO). An Incident Report or Formal Student Grievance Form may or may not be filed in these matters. The CRO will meet with the parties involved in a timely manner to discuss the details of the dispute. The CRO will mediate with the goal of resolving the conflict between the parties. If a resolution is reached by the parties involved, no further action will be required. The resolution may include sanctions.

Examples of Situations the Conflict Resolution Officer Could Mediate:

- Conduct Issues (student/student, faculty/student)
- Room-mate Issues
- Unprofessional & Inappropriate Behavior
- On Campus Dispute

III. Administrative Resolution

When a complaint or alleged violation of college policy occurs that involves more serious violations of college policy, an Incident Report, Notice of Concern (NOC) or Formal Student Grievance Form should be filed with the Health Center Administration/Conflict Resolution Officer of the College. The College will pursue issues of this nature whether a formal incident report has been filed or not.

Other Examples of Violations:

- Ethical Violations (including cheating on exams & plagiarism)
- Falsifying Documents (including signatures on documents)
- Safety Issues (including practicing Chiropractic without a License)
- Unobserved Adjusting
- Using Unapproved Techniques in the Technique Labs or Health Center
- Bringing a firearm to campus
- Being under the influence of drugs or alcohol while on campus or in the Health
Upon receipt, either the Health Center Administrator will review the completed Incident Report, Notice of Concern or formal Student Grievance Form and route it to the appropriate College Administrator for investigation and administration. The administrator will serve as the College Disciplinary Officer in the matter. They will schedule and hold a conference with the student charged and obtain his or her response to the alleged misconduct, except in instances where the student charged declines to cooperate, in which case the conference requirement is waived. The Disciplinary Officer may opt to resolve the complaint with or without sanctions. If the alleged student(s) admits culpability in the matter and a customary and usual Sanction (from the published list) is given based on the facts and seriousness of the issue, there is no appeal available to the student. The disposition of the matter will be provided to the accused in writing and be signed by the student and the Disciplinary Officer assigned to the matter.

If the student admits a violation of misconduct and the student can demonstrate that the sanction imposed is not the usual or minimum sanction given similar circumstances, the student charged may request a hearing on the sanction only. If the alleged student(s) does not admit culpability, they are entitled to meet with the Chair of the Student Judicial Committee and request a Judicial Hearing to review all facts of the Incident Report and during that Hearing the misconduct will be examined. Sanctions may or may not be given as a result of the evidence presented at the Judicial Hearing.

Neither legal representation for the accused student or the College, nor tape or electronic recording will be permitted during the Administrative Resolution process. (Pages 4-5 Disciplinary Policies & Procedures)

On occasion a Health Center Faculty may see the necessity to engage a student intern in a conversation to address an issue and provide a student with a learning opportunity or a written warning. These conversations can be documented using the following form to outline the issue raised, the exact specifics of the situation and the action steps required on behalf of the faculty and the students to address the issue raised. This form will be included in the Mentor/Practice Advisor Intern file and will serve as recod of conversations had and issues raised with a student during their internship. These issues may relate to Satisfactory Clinical Progress (SCP) or a potential Disciplinary matter.
<table>
<thead>
<tr>
<th>Nature of infraction/offense</th>
<th>Possible Administrative action to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued care past re-evaluation date without faculty authorization</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Unobserved/unauthorized patient care – anything not approved in the authorized care plan (PDCS) (This includes abiding by approved frequency of care)</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>PDCS not signed and accepted by patient.</td>
<td>Loss of credit</td>
</tr>
<tr>
<td>Patient care without faculty approval – anything not approved in the PDCS</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Failure to report Work Comp or PI case</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Fraudulent signatures</td>
<td>HC expulsion</td>
</tr>
<tr>
<td>Falsified records – including completion of any part of the record without the patient present</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Patient Abandonment—including failure to assign vacation relief or discontinued care without notification to patient and Practice Mentor</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Unprofessional behavior including argumentative behavior, verbal abuse to staff or faculty, or paying for patients' Health Center treatment</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Failure to keep patient appointment</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>Student patient seen as an outpatient</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>Failure to complete SOAP properly – including incomplete post note</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Failure to complete missing information in patient file as indicated by Blue Dot and Faculty Notes</td>
<td>Loss of patient care credits provided while blue dot remains unresolved related to blue dot</td>
</tr>
<tr>
<td>No Show for x-ray appointment</td>
<td>Loss of 5 outpatient adjusting credits and related x-ray credits</td>
</tr>
<tr>
<td>*Plagiarism on any HC assignment</td>
<td>Loss of credit for the assignment + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>*Cheating on Competency exam</td>
<td>Minimum 1 quarter HC suspension to expulsion</td>
</tr>
</tbody>
</table>

**Table 4**

<table>
<thead>
<tr>
<th>HIPAA Violation - See Section 3</th>
<th>1st offense:→</th>
<th>→ 3 page paper</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2nd offense:→</td>
<td>→ Two week suspension</td>
</tr>
<tr>
<td></td>
<td>3rd offense:→</td>
<td>→ Suspension up to expulsion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dress Code Violation - See Section 3</th>
<th>1st infraction: →</th>
<th>→ The intern will be sent home to change and will lose two outpatient adjusting credits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2nd infraction: →</td>
<td>→ The intern will be sent home to change and will lose five outpatient adjusting credits</td>
</tr>
<tr>
<td></td>
<td>3rd infraction: →</td>
<td>→ The intern will be sent home and will be immediately suspended from the Health Center for one week.</td>
</tr>
</tbody>
</table>

**Sanctions Within the Life West Health Center Include:**

**Health Center Suspension**
Separation of the student Intern from the Health Center for a definite period of time, determined by the Vice President of Clinical Operations.

**Health Center Expulsion**
The termination of student status for an indefinite period of time. Permission of the President of the College is required for readmission. The official transcript of the student is noted “DISCIPLINARY EXPULSION EFFECTIVE ____________”.

26
This notation will remain permanently on a student’s academic transcript.

**Alcohol and Drugs**
Any intern suspected of being under the influence of alcohol or recreational or mind-altering or psychomotor altering drugs will be removed from the Health Center immediately and reported to the Vice President of Clinical Operations for disciplinary action. The intern will be relieved of all Health Center duties and functions until all appropriate actions have been taken.

**Code of Ethics and Responsibilities**
The code of ethics for Life Chiropractic College West Health Center embraces the responsibilities and obligations of the interns and faculty.

- Each intern must follow all Health Center policies and procedures.
- Each intern is responsible for maintaining a professional attitude and behavior within and outside the college and Health Center.
- Each intern, when in doubt, must refer discussion of Health Center fees to the Health Center Operations Manager. See Health Center Information chain chart for proper question/answer authority.
- Each intern is responsible for his/her own work with patient files and all assignments related to the Health Center Advising program or classes (see also the LCCW Catalog and Student Handbook).

**Responsibilities of the Intern to the Patient:**
- The ultimate purpose of your efforts should be to affect the greatest health benefit for your patient. Patient neglect in any form, therefore, will not be tolerated.
- You should bear in mind the great responsibility your profession involves and should conduct yourself as to acquire the confidence and respect of your patients.
- You should attend to a patient as often, and only as often, as is necessary to ensure continued, favorable progress.
- The doctor/patient relationship gives you the opportunity to exercise powerful influence with the patient. This influence should always be used in a positive manner.
- You should develop an awareness of your responsibility to refer your patient appropriately when satisfactory results are not being achieved or when diagnosis indicates that other care is needed.
- Each intern is responsible for the accuracy and completeness of his/her patient records.
- You shall not discriminate on the basis of race, color, creed, gender, age, or ethnic background in the selection and/or care of patients.

**Responsibilities of the Intern to the Profession:**
- Professional conduct should be a priority of the intern. It reflects on the nature of the institution from which he/she will graduate, the profession at large, and the intern him/
herself.

- The intern should attempt to contribute to the enrichment of scientific knowledge whenever possible.
- The intern is encouraged to associate him/herself professionally, in state and national chiropractic organizations, in order to honor and dignify the chiropractic profession and to expand its sphere of influence.
- Any conversation with a patient who is under the care of another practitioner should observe the strictest caution and reserve. No course of conduct should be pursued that might directly tend to diminish the trust in any other practitioner.
- When attending a patient who is regularly under the care of another intern, the care plan as approved on PDCS by the regularly attending intern must be followed. Any additional recommendations or care can only come from an LCCW Health Center faculty.
- It is your duty as a good citizen to be vigilant for the welfare of the community and to do your part wherever possible. You should be ready to give counsel to the public on matters pertaining to your profession, such as structural biomechanics and ergonomics, general hygiene, and sound health and sanitation practices that help control and prevent epidemics.
- Avoid unguarded statements about chiropractic successes, which tend to produce misconceptions in the minds of the community.
- Always be prepared with proper, complete patient records to aid representatives from the LCCW Health Center in the event they are called upon to testify in legal proceedings or matters pertaining to the profession.

Rights and Responsibilities of the Students and Faculty

Students have the right:
- To know how their grade will be determined and those accurate records of progress will be maintained.
- To have clearly stated expectations, objectives, and requirements
- To have the opportunity and resources provided to meet objectives
- To have faculty accessible according to college guidelines
- To have knowledgeable faculty
- To be treated as individuals
- To be evaluated objectively
- To confidentiality
- To have input into the decision-making process
- To expect the Health Center faculty to demonstrate professionalism in all respects.

Students are responsible:
- To prepare for class and clinical experiences
- To avail themselves of and pursue experiences provided
- To meet curriculum requirements
- To do self-evaluation and set learning goals
- To be self-directed
• To be respectful and courteous
• To treat others as individuals
• To respect privacy and confidentiality
• To demonstrate professionalism in all respects
• To respect the faculty right to due process
• To evaluate faculty objectively
• To be honest, fair, and responsible

**Health Center faculty has the right:**

• To expect interns to be prepared for class and clinical experiences
• To expect interns to avail themselves of and to pursue learning experiences provided
• To establish curriculum requirements
• To expect interns to do continual, ongoing self-evaluation and set learning goals
• To expect interns to be self-directed and disciplined
• To be respected and treated courteously
• To be treated as individuals
• To privacy and confidentiality
• To expect interns to demonstrate professionalism in all respects
• To due process
• To an objective evaluation
• To expect honesty, fairness, and responsibility from interns

**Health Center faculty is responsible:**

• To provide a procedure for due process
• To provide information in regard to progress and how grades are determined
• To identify expectations, objectives, and requirements clearly
• To provide opportunities and resources to meet objectives
• To maintain accessibility to students
• To be competent practitioners
• To treat interns as individuals
• To evaluate interns objectively
• To maintain confidentiality
• To provide a forum for intern input
• To always demonstrate professionalism in attitude and behavior

**Satisfactory Clinical Progress (SCP)**
Federal regulations require that Life Chiropractic College West establish, publish and apply reasonable standards for measuring student's Satisfactory Academic Progress (SAP) in their educational program. The qualitative and quantitative standards used to monitor academic progress must be cumulative and must include all periods of the student's enrollment. This policy will be enforced at the end of each term. In the Health Center, this is referred to as “Satisfactory Clinical Progress (SCP)”. The following definitions apply to terms used in this
Clinical Plan: A plan, which if followed, should improve an intern’s ability to meet Life West’s Satisfactory Clinical Progress (SCP) standards by a specific point in time. Interns who have been placed on a clinical plan must meet the modified standards of clinical progress outlined in the plan or he/she may be dismissed from the Health Center.

Appeal: Appeal is a process by which an intern who is not meeting the satisfactory clinical progress standards may submit a petition, outlining the circumstances for his/her clinical performance and explain what has changed that would allow him/her to regain good clinical standing to the Clinical Standards Committee for reconsideration to remain in the Health Center program. After reviewing the petition, the Clinic Standards Committee may ask for more information and may request that the intern review their appeal in person with the committee. The decision of the committee is final.

If the first appeal is approved, subsequent appeals will only be considered if an intern’s reason for his/her clinical performance has changed from an earlier appeal. An intern may only appeal twice under this policy.

A ‘Record of Counsel’: Record of Counsel may be executed by any Health Center Faculty or Administrator and provided to either the Vice President of Clinical Operations or Dean of Clinical Education for review. The Administrator most appropriate for the nature of the conversation will meet with the faculty prior to engaging in a conversation with a student regarding an issue of concern relating to SCP or a potential for behavior in need of correction not outlined in the itemized list of disciplinary infractions on p.18. These issues will be addressed in both verbal and written form. They will serve as record on the Mentor/Practice Advisor student Intern file.

Completion Rate: Enrollment in the program cannot continue for an indefinite period of time. Interns are expected to complete their degree in the 14 (Standard) or 12 (Accelerated) terms scheduled in the curriculum. Some interns, however, require extra time to complete the degree. Time of completion for the Health Center requirements is four quarters.

Consequences of not meeting Satisfactory Clinic Progress (SCP): Life West interns are expected to perform at the highest academic and clinical levels. Those interns who do not meet the standards of Satisfactory Clinical Progress are subject to the following consequences:

Clinical Concern: A student may be placed on Clinical Concern whenever a clinical event occurs, which, if not corrected, may lead a student to fall below the minimum standards of SCP. A student on Clinical Concern is in good academic standing, and retains all rights, privileges, and financial aid eligibility of a regular student. Some of the events which may prompt a Clinical
Concern are:

Failure of any Clinical Competency exam more than two times
  • Three or more Notices of Concern in one quarter
  • Time of completion ten quarters maximum of Outpatient Care
  • Not meeting minimal patient activity requirements (minimum of three patient care or interactions per week)
  • No patient activity for ten or more consecutive weeks.

Interns, whose clinical performance reflects any of the above activity, should be aware that their future in the clinic and date of graduation may be impacted.

Clinic Warning
Clinic warning is assigned by the Dean of Clinical Competency to an intern who fails to make SCP and must meet the minimum standards by the end of the next term of enrollment.

Clinic Probation
Interns who fail to make Satisfactory Clinic Progress within one quarter immediately following a term of clinic warning will be required to submit a letter of appeal to the Clinical Standards Committee explaining the reasons for his/her clinic performance. This must be received by the Clinical Competency Office by Tuesday morning of the first week of the term. If the Clinical Standards Committee approves the appeal, it will develop a plan for the intern wherein he/she should be able to meet SCP within a certain time frame. Following this approval, the intern will meet with a representative from the Dean of the Health Center to review and sign the clinical plan. Approval of probation status allows the intern to continue in his or her program.

Clinic Dismissal
If, after being placed on clinic probation, an intern fails to meet the standard of Satisfactory Clinic Progress and/or fails to meet any of the requirements of the clinic plan (which must align with minimal clinical activity requirements), they may be dismissed from the Clinic.
If an intern who has been dismissed from the Clinic at a later point re-applies to the Clinic, he or she must also submit a letter of appeal to the Clinical Standards Committee for readmission and will likely need to repeat the Health Center Entrance examination/s as described earlier in this document to demonstrate retention of required minimal competency to participate in the Health Center activities.

Appeals may be made based on the grounds:
  • A death in the immediate family.
  • Serious injury or illness of a student or a member of the immediate family.
  • Special circumstances to be reviewed on a case-by-case basis.
Clinical Honors Recognition of Interns

- Intern of the Quarter: The highest producing intern of the Health Center each quarter will be recognized as Intern of the Quarter upon the recommendation of his/her advisor. This intern is awarded a certificate during the quarterly Health Center Recognition Seminar.

- Honors Program: In this program interns are recognized for their performance based on patient visit numbers in excess of minimal requirements while remaining in good standing in the Health Center and campus environments. ‘Good Standing’ means that an intern has not had any disciplinary action, is not on contract with either the Academic or Clinical Standard Committees and has not had to enroll beyond the typical 6 quarters of clinic to complete their requirements. To be awarded clinical honors, interns must also be achieving in terms of competence; honors recipients must be achieving competence in all three areas of assessment (CMR, ROF, and PVE). Additionally, honors interns must receive the recommendation of their mentor doctor and at least one full-time floor faculty member.

Recognition will be awarded to interns who achieve patient visits of 300, 350, 400, 450 and more than 500.

- Interns are recognized for ALL patient category visits including: student, courtesy and outpatient adjustments.

- Note: the student (and student courtesy patient) adjustments are NOT counted towards the outpatient graduation requirements and only towards Honors recognition in the Honors Program.

Clinical Excellence Citation

The highest CLINICAL honor that can be bestowed upon a graduate is the Clinical Excellence Award. This award recognizes the student that has both skillfully and successfully found the combination of outstanding doctor-patient relationships, professional attitudes, clinical knowledge, skills and judgment. Upon recommendation by the HC Administration Group, the intern is chosen on the basis of the following criteria and conditions:

Completion of all clinical requirements

- Achievement of 250 or more patient visits on or before the last day of the second month of the graduation quarter.
- Review of the candidate’s number of Intern’s Qualitative Assessments graded as ‘Competent’ and ‘Proficient’ across all assessment types.
- Review of the candidates Health Center Advisor file, including any Notice of Praise or Notice of Concern statements and all Health Center examination results.

- Clinical knowledge and judgment
- Chiropractic adjusting skills
- Communication and interpersonal skills
- Professional attitude and behavior
- Quality of record-keeping
- Leadership
- Overall commitment to excellence
- Following review of the HC Advisor file, the remaining candidates must be approved by each of the Health Center department administrators (Competency, Compliance, and Imaging).
- Final determination will be made by a vote of the Health Center Faculty and The recipient of the Clinical Excellence Citation will receive his or her award during the college’s HC Recognition Seminar and/or Graduation Ceremony.

### Table 6

<table>
<thead>
<tr>
<th></th>
<th>300</th>
<th>350</th>
<th>400</th>
<th>450</th>
<th>500+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRONZE</strong></td>
<td>Honor pin</td>
<td>Honor pin</td>
<td>Honor pin</td>
<td>Honor pin</td>
<td>Honor pin</td>
</tr>
<tr>
<td>Honors medal with WHITE ribbon</td>
<td>Honors medal with GRAY ribbon</td>
<td>Honors medal with YELLOW ribbon</td>
<td>Honors medal with DARK GREEN ribbon</td>
<td>Honors medal with DARK BLUE ribbon</td>
<td></td>
</tr>
<tr>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>300</th>
<th>350</th>
<th>400</th>
<th>450</th>
<th>500+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRONZE</strong></td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Framed “Regular” LCCW Diploma (from the frames at the Bookstore)</td>
<td>Framed “Regular” LCCW Diploma (from the frames at the Bookstore)</td>
<td>Framed “Regular” LCCW Diploma (from the frames at the Bookstore)</td>
<td>Framed “Regular” LCCW Diploma (from the frames at the Bookstore)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A LCCW Re-licensure sponsored seminar Complimentary for 5 years post-graduation date.</td>
<td>A LCCW Re-licensure sponsored seminar Complimentary for 5 years post-graduation date.</td>
<td>A LCCW Re-licensure sponsored seminar Complimentary for 5 years post-graduation date.</td>
<td>A LCCW Re-licensure sponsored seminar Complimentary for 5 years post-graduation date.</td>
<td></td>
</tr>
</tbody>
</table>
Health Center Manual

Section Two

Health Center Patient Care and Procedure

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center's policies and procedures as needed.
PATIENT FILES

General Instructions
1. Every page must have the patient information and intern information filled out at the top.
2. All blanks must be filled out, legibly, using longhand and standard abbreviations only.
3. All writing in the patient files must be filled out in blue or black ink, no other colors. You may not use felt tip pens (including hi-lighters), pencil, fine point pens or erasable inks. If changes are necessary, cross out the error with one line, and initial the change. No whiteout or any other manner of erasing is permitted.
4. The Patient Information form, which is filled out by the patient, must be completed and signed by the patient or legal guardian. It is included in the case file as part of the permanent record. Read this form after the patient has completed it.
5. All forms are legal documents and must be completed with this in mind.

Page Order
(See sample files in the SHC and in front of Records Room in the Health Center)

Right side of Patient file:
- **PDCS** (most recent on top)
- **SOAPS** (oldest SOAP is on top of all SOAPS, most recent on the bottom, by the exams)
- **Examinations** (most recent on top) including
  - **Re-evaluation exam with new concern**: Blue history of new concern, Yellow “re-eval patient survey and examination” form, (purple) OAT for new complaint, (purple) RAND 36, Wellness, blue exam form for new complaint, instrumentation, and narrative, chiro up research and handouts.
  - **Re-evaluation exam**: Yellow “re-eval patient survey and examination” form, (purple) OAT for main complaint, (purple) RAND 36, Wellness, if there is an exam (blue) it goes here, instrumentation and narrative, chiro up research and patient handouts after narrative.
  - **Transfer, Reactivation or Initial Physical Exam**: Reason for Seeking Care, Patient survey, next are (pink) additional complaints if needed, (purple) OAT for main complaint, (purple) RAND 36, Wellness Questionnaire, (if PHQ 9 or GAD 7 are needed, they go here), Review of Systems, Diagnosis Worksheet, Chiropractic Screening exam, all blue exams, instrumentation, Summary of Findings and Imaging Request, Narrative, chiro up research and patient handouts after narrative.

- **Lab Request** and Narrative (most recent on the bottom of the Lab Section)
• DACBR Report  (most recent spine on the bottom)

Left Side of the Patient File (not as strict about the order on this side of the file, as long as the faculty notes are first):
• Faculty Notes page
• Informed Consent page
• Doctor Referrals/ Reports/Disability reports
• Patient Information Sheet
• HIPPA forms
• Patient ID

SPLITTING A FILE
Patient Files may need to be “split” if the file gets too thick, or the folder is ripped so that forms could fall out. This procedure is also followed when an outpatient becomes a student or vice versa. When a new folder is created on an existing patient, the following are included in the new file in the following order:

Left Side of File: All original forms from old file are put into the left side of the new file. This includes:
• Faculty Notes page (on top)
• Any Referral forms should be placed directly under the Faculty Notes page(s)
• Informed Consent(signed)
• Patient Information sheet and New Patient paperwork
• Insurance information forms filled out at this Health Center
• HIPPA forms.

Right Side of File: The following Original forms are kept in the new file:
• Recent PDCS (can keep up to one or two years and the rest can go into the old file)
• Recent SOAP notes (Can keep the most recent intern’s SOAP notes and some of the previous intern’s SOAP notes)
• Physical Exams of the most recent intern of record exam (i.e., Re-evaluation Exam/s and Transfer exam) and one or two of the previous intern’s exams
• Laboratory report if less than one year old
• All radiology reports. The most recent DACBR report is the last page of the patient file.

The records room does not need to make copies of these forms that are kept in the new file to put in the file that goes to archives.
*This does not include starting a new Personal Injury File on an existing patient.

**Records of the Health Center**
Patient records are to remain within the Health Center at all times. Patient records (patient files and x-rays) may be checked out for use within the Health Center through the records room staff. The intern will complete and submit a red “out-guide” to the staff to be placed in the filing shelves when a file is to be checked out. The intern can use a green “out-guide” to place a file on hold for another time. The records must be returned to the records room the same day they are checked out. NOTE: no more than three (3) files can be checked out at one time unless the files are for a family.

Patients are not to be checked into the Health Center later than 45 minutes prior to scheduled Health Center closure; records are to be returned to the records room no later than 15 minutes prior to closure time.

**PT Equipment and Supplies**
The Health Center maintains physiotherapy equipment in the records room. This room is located within the records room of the Health Center. The following are some items* available for patient purchases: heel lifts, supports, Theraband, and ice packs.

The intern must make sure of the following:
- The items purchased must be included in the case management and approved on PDCS.
- The mentor signs the visit slip at the time of the visit for the appropriate item.
- Faculty completes a heel lift form for heel lifts.

*No item, other than those authorized on the PDCS may be sold, provided, or recommended to any patient, unless recommended by a mentor under Acute Care Protocol. This includes nutritional supplements.

- The intern presents the visit slip (and heel lift form, if applicable) to the records room and they record the price of the item on the slip.
- The patient pays for the item at the cashier’s station.

**PATIENT CARE PROCEDURE**

**New Patient Information/Forms**
All new patient intake forms can be found on the LCCW website at www.lifewesthealthcenter.com. Have new patients complete these forms, save to their desktop and submit to the Health Center. The completed forms will be emailed to the New Patient Desk and a new file will be prepared for the patient prior to his/her arrival. If the new patient has not completed these forms prior to his/her first visit, he or she can complete them electronically or on paper at the time of arrival. Please allow 30 minutes for this
process before seeing the patient.

**Online Forms Include:**

- Patients will be submitting the following forms to the front desk prior to their appointments:
  - Reason for Seeking Care
  - Patient Survey (Pain Diagram)
  - Wellness Questionnaire
  - Review of Systems
  - Quality of Life Health Survey Questionnaire (RAND 36)

The intern should look through these and make additional notes as they are discussed with the patient on their first appointment.

**Reason for Seeking Care (i.e., Chief Complaint)** (See sample On Canvas)

In case the patient did not fill out the paperwork prior to their appointment, use the Reason for Seeking Care Form for recording the patient’s complaints. In the event there is more than one complaint, use the History of Additional Complaint forms that are on the wall. Use as many forms as necessary.

Not all patient complaints are chief complaints. It may not actually be the patient's most serious problem, but it may be uppermost in the patient’s mind. The chief complaint is the complaint which actually motivated the patient to seek health care.

**Health and Wellness Questionnaire** (See sample on Canvas)

The Wellness Questionnaire Form can be completed by patients prior to coming for their appointment, on the Life West web page. Review this with the patient and make follow-up notes on the bottom of the page.

**Review of Systems (ROS)** (See sample on Canvas)

During the initial, transfer, or re-activation exam, the patient will complete this ROS Form and the Wellness Questionnaire prior to their appointment. This can be filled out by the patient online prior to their appointment. Any ongoing or significant issues need appropriate details which may be written on the following page by the intern while taking the history.

**Case History - Diagnosis Worksheet –** (See sample on Canvas)

The Intern will document the significant findings from the ROS, such as details regarding traumas, etc. The working Diagnosis(es) are listed along with the most likely conditions and differentials. Both the intern and the faculty sign this page and check off the required exams and
OATS before the physical exam may begin.

**HPON (History, Physical, Ortho/ Neuro) Complaint**
These pages are actually a set of forms and the core of the patient’s file. They contain the following:

- Reason For Seeking Care/Additional Complaint(s)
- Pain Diagram, Wellness Questionnaire, ROS, OATS
- Physical, Orthopedic, Neurological, and Chiropractic Examinations
- Imaging Evaluation and Request
- Case Summary Narrative which includes the X-ray narrative
- DACBR report (if applicable)

**Pain Diagram – (See sample on Canvas)**
The patient must mark all complaints Experienced within the last three months on this diagram.

**Physical, Orthopedic, Neurological, and Chiropractic Screening Examination**
In completing the examination, be thorough, do not leave blank spaces on the Chiropractic Screening Examination Form, NAD = no abnormality detected. All abnormal findings require detailed comments on the blank lines provided at the end of each page. Note that in some areas “go to sp#” indicates special procedures need to be performed. The special procedure form is found on the forms wall in the Health Center. Summary of Findings and Imaging Request

**Summary of Findings and Imaging Request**
The Summary of Findings and Imaging Request should be completed by the intern in consultation with the HC faculty following all initial, transfer, and re-activation examinations even if x-rays are not requested. Include all history and exam findings for all complaints. Faculty signature is required at the bottom of this page and on the visit slip prior to releasing the patient.

**THE NEW PATIENT PROCESS**
Prior to a patient’s first visit, the intern must schedule the new patient coordinator, new patient, and initial exam in the MindBody scheduler for the new patient. If possible, have the patient complete the new paperwork online at www.lifewesthealthcenter.com.

When a patient enters the Health Center for the introductory consultation and examination process, the following should occur:

- The patient presents to the receptionist for instructions (if the new patient paperwork
was

- Completed online and submitted, there will be a file ready for patient signatures. If this has not been completed, the new patient paperwork will be completed at this time and a file will then be compiled for the final information and signatures.
- The Chiropractic Assistant will page the intern when the file and visit slip are ready.
- The intern assists the patient to a consultation/examination room and completes the Patient Case History, Review of Systems and Wellness Questionnaire making notes as appropriate.
- After completing the Case History Diagnosis Worksheet, the intern will take the file to their mentor to select appropriate OATS forms and examinations.
- The mentor will determine if the patient should follow the acute care procedures, personal injury protocols, standard care procedures, or requires immediate referral and the mentor will authorize the examination with their signature.
- Once determination of protocol has occurred and OATS have been completed, a Health Center faculty signature authorizes the intern to perform the physical exam.
- The intern may then proceed with the physical exam.
- Upon completion of the examination, the intern completes the Summary of Findings and Imaging Request form, getting approval from the mentor to proceed. The mentor signs all appropriate forms including signing off for required x-rays as indicated.
- Necessary x-rays are taken (walk-in availability immediately after the faculty signs approval) or appropriately scheduled. The x-ray department faculty initials all appropriate imaging forms.
- The patient presents her/himself to the cashier line for processing of the charges/payment information and intern credit input.

**Re-Activation Patient Process**

Re-activation: Any patient file, having been inactive for more than one year but less than three years, requires a complete history and examination. This is true even when there is no change in the intern of record. The following examples would be considered a re-activation:

- One year since last patient visit.
- File had been previously inactivated.

The procedure will be the same as if the patient is a new patient. Patients who have been inactive for three years or longer are considered as new patients and if recruited back to the Health Center by the intern, will count toward the 5 New Patients required for graduation.

**Transfer Patient Process**

When a student patient is transferred to a new intern, the intern of record should introduce the
new intern to the patient as well as let the patient know that their case has been discussed with the new intern. It is also highly recommended that the new intern observe a few visits so that the patient is confident that the new intern is familiar with all aspects of his or her case.

When a courtesy or outpatient is going to be transferred to a new intern, the intern of record must introduce the new intern to the patient as well as let the patient know that their case has been discussed with the new intern. It is also required that the new intern observes a few visits so that the patient is confident that the new intern is familiar with all aspects of his/her case.

Notation of the new intern observation of a visit will be made in the S.O.A.P. notes and initialed by the mentor at the time of the visit. The new intern of record may then schedule a transfer exam with the patient.

**Transfer Process**

(These first three steps may occur prior to the patient arriving for his/her first transfer visit):

- As the transfer patient arrives for the exam and obtains the visit slip, the intern proceeds to the records room and gets the transfer clipboard.
- The intern writes the appropriate information onto the form and brings it to the mentor to sign off the transfer.
- The intern gets the approval of their mentor who will then assign the patient to the intern in the faculty notes.
- The intern assists the patient to the consultation/examination room and proceeds with the history and exam, obtaining signatures as needed as in the new patient process.
- The new intern of record is allowed to see their patient up to 4 times as they are completing the history and exam and prior to completion of the PDCS (PDCS should be completed within 24 hours of completion of the exam).
- If the mentor agrees to the visit, the mentor writes transfer visit (TV) next to the SOAP Note and on the visit slip.
- The Transfer Visit (TV) must be approved before the intern begins writing up the S.O.A.P. note for that visit. The new intern must follow the prior intern’s approved case management plan until the new PDCS is completed.

**THE ACUTE CARE PATIENT AND PROTOCOL**

The acute care patient is one who has severe pain of recent onset or exacerbation that prevents them from engaging in their normal daily activities. The condition of the patient must be supported by the objective findings of the examination. The patient’s status is verified by, and each subsequent visit must be cleared through the mentor. The following protocol is observed:

- Prior to assigning acute care status the intern should obtain history of the chief complaint, review of systems, and pain diagram.
- After completion of the history, the file is brought to the advisor who will determine if the
history suggests acute care status. If the HC Faculty (ideally the student’s Mentor) feels the patient may qualify for acute care status, they will meet the patient to verify.

• If the HC Faculty decides the patient is acute, the intern will then perform a regional exam of the area of chief complaint (blue form) as well as take vitals. Additionally, as much of the full physical exam as possible must be performed at this time.

• Upon completion of the initial exam, the HC Faculty will approve necessary x-rays of the area of chief complaint. These must be taken prior to care. All attempts will be made to fit acute care protocol films into the imaging department schedule for that day.

• The HC Faculty will supervise OR provide the acute care until the patient’s exam is completed and the care plan is approved via PDCS. This is at their discretion.

• Within two (2) to three (3) subsequent visits (or as soon as is tolerated by the patient), the intern should repeat the regional exam and the remainder of the physical exam.

NOTE: Student will receive credit for initial visit, examination etc. and any adjusting credit they perform unless the HC faculty member performs the adjustment. Once a PDCS has been completed and signed, the student will resume the care as it usual and customary.

**Minor Patients**

Individuals, who are 17 years old or younger, if accepted as patients need appropriate written parental/ legal guardian authorization. Parent/legal guardian must be present with the patient in the room for all procedures. X-rays are taken based on clinical need and only with parental consent, following a complete explanation to the parent/guardian regarding x-ray exposure, technique alternatives, etc.

**Sample of the LCCW Health Center’s Pediatrics Exam**

Minor patients will be processed using the approved Pediatric forms available in the forms folder on Canvas.

**Pregnant Patients**

Patients who are pregnant may be accepted as patients for chiropractic care. X-rays are taken only if there was recent trauma, in which case only minimal x-ray studies are taken.

**Trauma Patient Protocol (Personal Injury)**

The intern is to immediately notify their mentor in the event that a patient presents with a history of recent trauma. It must be determined if the case should be assigned a personal injury case. A complete history of the incident must be taken, documented, and discussed with the mentor before further orthopedic or neurological testing, care, or ancillary procedure is provided to the patient.
Personal Injury
Although it is always necessary to adhere closely to the Health Center protocol, it becomes especially important to do so in Personal Injury cases. These cases, for various legal reasons, require an increased amount of documentation and precision in record keeping. The patient may be seriously inconvenienced in terms of the legal outcome of the case, should the Health Center fail to manage the case in an appropriate manner. The Health Center and individual mentors are equally exposed to unnecessary problems should the intern fail to carry out their responsibilities properly.

Interns who collaborate with D.C.’s on these challenging cases are afforded an excellent opportunity to obtain a great deal of on-the-job training in chiropractic injury protocols. It is with this in mind that interns carefully read and adhere to the protocol described below.

Determination of a Personal Injury case is best made before or during the initial consultation. The patient may have informed the Health Center receptionist or other chiropractic assistant on entrance or may have included a notation on our patient intake forms. If there is no indication of injury, it is still appropriate during the consultation to ask, “Have you been hurt at work or have you been in an automobile accident or some other kind of accident?” The Health Center no longer accepts Workers’ Compensation cases and will refer the patient to a chiropractor in the field if necessary. If the patient reports that their condition is associated with their job the mentor should be consulted immediately.

The intern is to notify the mentor immediately when injury is suspected. Documentation of the injury or suspected injury then becomes necessary concerning the circumstances of the case: where and when it took place, whether a report was filed, and the name and address of insurance carrier/attorney.

Some patients prefer that their job-related or auto accident injuries remain unreported. In all cases, the mentor will interview the patient and make notes in the file indicating the appropriate course of action. Personal Injury patients can be accepted and approved only by the Mentor. The intern, under the direction of the mentor, is responsible for completing all normal and additional procedures relating to the case including:

- Phone calls for miscellaneous information
- Supplementary forms and reports
- Narrative reports, supplementary examinations and Imaging Request (Supplemental)

HIPAA (See Section 3)
INITIAL PATIENT CARE
The Life West Health Center seeks to ensure that quality patient care is delivered in a timely manner. Patients expect that interns and faculty will be able quickly understand from the history, examination, and required imaging or other tests, what is going on (a diagnosis) and to deliver a care plan within a reasonable period of time. The intern working with the faculty mentor will therefore develop an appropriate diagnosis and chiropractic care plan or refer the patient out, within 24 hours of completing all initial workup procedures. The following pages outline the documentation of this process. This form is the Patient Diagnosis and Care Summary (PDCS) form.
Supplemental Care

Faculty Initials/Date  Modalities:  □ N/A

Faculty Initials/Date  Active Care:  □ N/A

Faculty Initials/Date  Lifestyle Recommendations:  □ N/A

Faculty Initials/Date  Diet/Nutrition:  □ N/A

Faculty Initials/Date  Support/Pillow/Orthotics:  □ N/A

Faculty Initials/Date  At Home Care Recommendations:  □ N/A

Faculty Initials/Date  Restrictions (Home or Work):  □ N/A

Faculty Initials/Date  Referrals:  □ N/A

Faculty Initials/Date  EIP References:

Faculty Signature – Approval of supplemental care  Date

Intern Signature  Date

Patient Signature at ROF (Initial any requested changes)  Date of ROF (Patient signed date)
Guide to Patient Diagnosis and Care Summary (PDCS) form

1. Fill in Intern name, DOC#, and Mentor name (of the intern who is assigned to the case). Fill in patient file number and age and the date this form is completed. Do not fill in patient name until this is presented to the faculty mentor and then the name is to be written in by hand in blue or black ink.

2. DO NOT FILL IN THIS SPACE. This is for the faculty mentor to complete.

3. There must be a complete problems list diagnosis with appropriate ICD-10 codes to begin care, the signing faculty member reviews and approves the intern’s diagnosis. Enter ICD-10 codes in the box “ICD10 Code” and write out the diagnoses in the “Diagnosis” box. Maximum of two Dxs per complaint. You may enter the subluxation/s as one line, i.e. subluxation of cervical, thoracic and pelvic regions or subluxation of the upper cervical spine. Then no more than two DXs per complaint.

4. Pertinent x-ray or other imaging findings are recorded in list format (can consult with DACBR report or DACBR on duty)

5. Goals of Care, list goals in terms of patient reported desired outcomes and outcome measures.

6. It must be indicated on the form that the patient has been evaluated for contraindications. If none are present check “NO,” if contraindications are present check “YES” and list them on the form.

7. Management Plan, the management plan consists of Chiropractic care (adjustments), all other "Supplemental" Care (any ancillary care including but not limited to: PT modalities, active care, at home recommendations, supports/pillows/orthotics, diet/nutrition, life style recommendations, restrictions, and referrals all of which are included on the second page of this form), the goals of care, and the EIP references.
   a. Chiropractic Care, list Technique or Techniques to be utilized with this patient.
   b. State the frequency of care (number of times per week) and then the outcomes that will be used to determine that a change in the frequency is indicated (outcomes may include: changes in instrument readings, improvement on specific OATs assessment, a target level or range on a pain scale, improved function demonstrated on functional assessments)
   c. Care Considerations; list any considerations that need to be made in caring for this patient.

8. First Faculty signature approving care plan before ROF and Informed consent. (note: this signature approves the care plan, care CANNOT begin until the ROF and informed consent is complete and verified by the patient signing and dating in box 8) The Intern must also sign at the time the faculty approves care. The approving faculty member will determine expiration up to 12 weeks from the date the exam was completed. The care plan listed on the form is valid for through the date is this box (8).

9. When the ROF and informed consent are complete and after the patient has signed in box 8, the faculty member must initial informed consent before care begins. If the ROF was assessed, the faculty will also initial the ROF Assessment.

10. Use this section for details of supplemental care
a. Supplemental Care, list any care (other than chiropractic care) to be provided. These are listed here, with frequency. Details such as how to do exercise, or specific diet or nutritional details etc. should be attached to this plan and provided to the patient.

b. You are not required to enter something in every box. You are required to make appropriate recommendations considering what is most important to this patient during the phase of care being described. Check N/A if appropriate and fill in each box as appropriate.

11. EIP References, list all referenced used to create the care plan

12. This second signature box is for the Supplemental Care. This may be completed by the Mentor or may be completed by a floor doctor. The Mentor will decide to approve the supplemental care plan or refer the intern to one of the floor doctors. The intern may, of course, request consultation with a floor doctor based on individual expertise. Note, each portion of the supplemental care plan must be initialed by the faculty doctor who approves this section (your mentor may approve one or more sections, but refer you to a floor doctor for other parts or the entire supplemental plan. NO SUPPLEMENTAL CARE MAY BE DELIVERED OR INSTRUCTED TO THE PATIENT UNTIL THIS PORTION OF THE CARE PLAN IS APPROVED (ALL APPROPRIATE SECTIONS INITIALED AND THE PAGE IS SIGNED AND DATED BY A FACULTY DOCTOR). Portions of the supplemental care plan may expire as the patient progresses through stages of care (i.e. reduce/alter certain modalities or home instructions as the patient progresses from acute to sub-acute to chronic). In such cases, please include this progression in the supplemental care instructions on this page. The patient must sign and date acknowledgement of ROF related to supplemental care whether these were introduced at the first ROF or at a subsequent date. DO NOT PROVIDE CARE WITHOUT COMPLETING THE ROF.

Key Considerations:

- This form is good for up to 12 weeks from the completion of the exam.
- Use standard informed consent along with this form.

CASE MANAGEMENT REVIEW (CMR) PROCESS

Case Summary Narrative (Sample – on Canvas)

As of fall 2019, interns will be required to complete on Case Management Review per quarter. This will be a comprehensive review of a file that the intern has had under care through at least one re-evaluation. The intention is to thoroughly review the case and complete a reflective and retrospective evaluation of the case which is transparent and acknowledges successes and that which needs or could be improved.

The process will be conducted as follows:

At the end of each quarter (by week 8), the mentor and intern will select one case for review the
following quarter. The minimal criteria include:

- Must have had initial, transfer, or re-activation exam with the current intern
- Intern has seen patient at least three office visits
- The current intern has completed at least one re-evaluation

Additional criteria to be considered are complexity of case (more complex is considered better for this exercise), positive or challenging results from care, and any special circumstances that may make the case unique. DO NOT select cases with no complaints. DO NOT select cases with so many complaints that the review with the floor doctor cannot be completed within the one hour time frame that is scheduled.

All interns SC2 through Clinic four will have one case reviewed each quarter. SC2 cases will be the reciprocal case from the SC1 quarter. C1 through C4 will be based on criteria above and must be selected with approval from the intern’s mentor.

Interns will schedule a one hour CMR time in MindBody with the front desk staff during weeks three, four, five and six of the quarter (the schedule will be available by week one of the quarter). Between the selection of the case in week 8 and the scheduled CMR appointment in the following quarter, the intern will prepare a detailed narrative based on the CMR narrative template provided on Canvas.

During the CMR, the intern will review with the HC faculty the case verbally and have the opportunity to discuss the case including: history, exam, x-rays, differential diagnosis, final diagnosis, evidence informed care plan, goals, and outcomes of care. This is a retrospective analysis of the care, so the intern will also be required to report and discuss the outcomes of care so far including patient response and compliance and future plans and goals for this patient. This retrospective look is to be transparent, such that errors are recognized, possible improvements to the plan are considered, and the intern acknowledges the learning opportunity.

The CMR will be assessed based on the CMR rubric. Feedback will be provided for any section that is not assessed as at least competent. If all sections are assessed as competent, the intern has completed the assignment. If any sections are assessed less than competent, the intern will be provided feedback in order to make necessary corrections and immediately scheduled for a return appointment with the same HC faculty during weeks seven, eight, nine or ten of the quarter. This will give the intern the opportunity to make corrections and improve their assessment. The faculty member is not expected to provide the “answers” to the omissions or errors that lead to a less than competent assessment, but rather some direction that will help the intern in their own effort to improve. Interns may consult with peer mentors, floor faculty, or other faculty in the development of the CMR narrative and presentation.
Minimal requirements are two competent assessments from Clinic 1 through 4.

**Blue Dots:** If more information is needed in the file, a blue dot will be placed on the patient file by the faculty who are completing the CMR or PDCS. A blue dot means that there is some information missing in the file that the intern needs to complete. Interns have two weeks from the time the blue dot is put on to complete the file. Interns should see their practice mentors (mentors) for further instructions. Interns may bring the file to their mentor or the CMR faculty who put the blue dot on the file to make sure the file is complete.

**Writing a Clinical Impression/Diagnosis**
A diagnosis at the Life West Health Center shall be written as a prioritized problems list. The final diagnosis is determined from all the information obtained as a result of history, physical examination, x-ray examination, labs, and any special studies. The diagnosis shall include, but is not limited to, subluxations of the spine/pelvis and/or extremities, all conditions relative to the chief complaint(s) and additional complaints. In addition, incidental findings, co-morbidities and all conditions that are to be referred out or co-managed with another health care provider. All descriptors (i.e. acute, sub-acute, chronic, mild, slight, moderate, severe, occasional, intermittent, frequent, and constant, etc.) are to be used when appropriate. The following is a description of how to write the diagnosis in the patient narrative.

Diagnosis/Problems list: The diagnosis should be grouped by complaint with each complaint listed separately based on the patient’s priority.

**Complaint with Applicable Modifiers**

**Subluxations of:** list by region or level. This is one line that states, “subluxation of…” and does not need to be per area of diagnosis.

**Neurological Diagnosis:** Write condition causing patient’s complaint. This condition was considered due to (relevant information from the patient’s history). It was confirmed by (information obtained from the exam and pertinent radiographic imaging).

**Structural diagnosis(es):** from x-rays that pertain to chief complaint i.e., DDD L5-S1, facet sclerosis, scoliosis, spondy.

**Functional diagnosis(es):** i.e., aberrant posture, indicate what type, i.e. upper cross, lower cross, cervical hyperlordosis

**Soft tissue diagnosis(es):** for region sprain/strain, muscle spasm, myofascitis, bursitis, tendinosis/itis, etc.
Co-morbidities: These are health considerations that make it harder for the patient to heal, i.e. smoking, diabetes, obesity, heart disease. This does not include family history issues.

PROGNOSIS & GOALS

PROGNOSIS—support your choices based on the following guidelines.

Symptomatic prognosis:
- How severe and frequent the symptoms are at intake. More severe symptoms generally take longer to resolve
- How long the symptoms have been present. The shorter the time, generally the better the prognosis.
- Number of areas of complaints. The more going on with the patient, the longer it takes the body to heal.

Functional prognosis:

Lifestyle: bad habits, sedentary lifestyle, poor posture
- co-morbidities may make it worse
- age
- job requirements
- Include an OATS scale expectations. A low (OATS) score would make the prognosis good to excellent

Structural prognosis is based on abnormalities found on posture analysis and/or x-rays
- Minimal DJD or DDD, the prognosis is probably good
- Spondylolisthesis may be fair to good, depending on how stable it is.

DEFINITIONS FOR SYMPTOMATIC AND FUNCTIONAL PRONOSES

EXCELLENT—Resolution (90-100% improvement) of problem expected in average or faster than average time frame.
GOOD—Improvement (60-80%) expected and will take average amount of time for healing and change to occur.
FAIR—Some improvement (about 25-50%) expected but will take longer than average. POOR—No improvement expected.

GOALS

Goals must be specific and measurable which means there should be numbers involved.

Functional goals: “increase lumbar flexion by 10°”, or “increase ability to single leg
stance to 60 seconds” or “decrease anterior head carriage by 1 inch” or “improve RM-LB score to minimal disability”.

Pain goals should address intensity of pain and frequency of pain.

**AUTHORIZED TECHNIQUES**

Only the techniques and analysis procedures taught in the LCCW Technique Labs are allowed in the Health Center.

An intern must have successfully completed on-campus course work in a given technique prior to using that technique in the Health Center. The intern will receive authorization to use elective techniques from the Health Center Registrar reflected on their ID badge. At least 125 of the required 250 patient adjustments must be made using techniques from the core technique curriculum. These techniques include Diversified, Gonstead, Integrated Drop Table, and Toggle techniques. The remaining 125 adjustments may be made using elective techniques for which the intern is qualified. These techniques include Activator, Chiropractic Biophysics (CBP), S.O.T., NUCCA, Evolutionary Percussive Instrument Correction (EPIC), Blair, and Upper Cervical Knee Chest. The visit slip has a separate designation for the elective technique adjustments and the intern credit report will indicate the number of elective adjustments performed.

**Ancillary Procedures (Physiotherapy)**

No physiotherapy modality may be used until the PT Modalities course has been passed. Pre-authorization is required for all PT use included on the PDCS and must be approved by the faculty at the time of each visit. The instrument, settings, duration of treatment and area of treatment will be documented in the case management plan, and approved by faculty during on the PDCS. All applications of PT must also be documented in the visit record (i.e., SOAP note) and are posted on the visit slip. SOAP note documentation includes the area it is being applied to, duration of the application and instrument.

All PT applications are to be approved and observed according to normal Health Center standards and procedures. **A patient may not be left unattended during the use of any modality.** PT is provided only in conjunction with specific chiropractic care: either preparatory to or subsequent to, but never in lieu of, chiropractic adjustments. To check out PT equipment: complete the S.O.A.P. notes, including faculty authorization for the PT procedure, and obtain the equipment from the Records Room. Faculty will sign the visit slip after the PT has been performed. Interns need to leave their keys/ property to take out PT equipment.

**Documenting PT in the File:**

Your specific settings should be spelled out in your case management plan in your Narrative. In your SOAP notes, you need only put the modality, the amount of time you will be applying it, and the
area you will be applying it to in the P portion of the SOAP note. The Objective portion of the SOAP note must support the need for the modality. Prior to performing any PT:

You must have it written in the file on the PDCS page and in the SOAP notes. You must have it initialed by faculty in the SOAP notes for the Records Room to provide you with the appropriate modality. After the PT has been provided to the patient, the faculty will sign the visit slip.

If you want to add PT that is not in your case management plan, you may ask the faculty for a one-time trial. After that, if you wish to add it to your care plan, you must edit the PDCS with the approval and in consultation with the faculty mentor. If Pt is being performed on an outpatient, it must be done in the practice areas or PT area. If PT is being performed on a student, it must be done in the student health center during regular student health center hours.

REPORT OF FINDINGS
Reports of findings happen in stages. To be done well, this is not one event but a series of the following: Pre-consultation, history taking, examination, creating a care plan, and then delivery of the report of findings. In the Life West Health Center, the report of findings is given following the care plan approval via the PDCS with faculty signature verifying authorization. The following provides an outline to assist in this process and can be considered as a skeleton. Use this and fill in details based on your patient’s history, exam, x-rays, care plan and needs.

1. Pre-Consultation
   a. Welcome the patient – greet them and introduce yourself

   b. Give brief tour as you’re walking to the exam room
      i. “This is where I’ll be seeing you on a visit to visit basis”
      ii. “Today we’ll spend more time in this exam room so we can talk about your health history and do some (special) testing to see how we can help”

   c. Frame the experience by telling them how long they’ll be here and what they can expect. Put them at ease and answer their questions before they can ask them
      i. “We’re going to spend about (an hour and a half) together today. We’ll talk about you and your health and what specifically brings you in here and as soon as I know whether or not I can help you, I’ll let you know.”

2. History
   a. Take proper history as taught in class and per clinic protocol

   b. Specifically ask about trauma, namely: car accidents, fracture, sports injuries, etc.

   c. Explain the mechanism:
i. “What I think happened is that you took a bump some time (refer to above history answers) or you fell off the swings or the monkey bars or something and you caused some sort of trauma to your body that it couldn’t handle. This usually causes a misalignment in the spine which then affects the function of the nervous system.”

d. Explain the subluxation (use your own words).
i. “The spine protects the nervous system, and when it is misaligned or not moving properly, it puts pressure on the surrounding areas of the nervous system – like the brain stem, spinal cord or any of the nerves that exit the spine – and this will cause messages between the brain and body to be affected. When this happens, it can result in pain, which is common, but more importantly it affects the function of the nervous system that could cause all sorts of different issues. Sometimes digestion is affected, sometimes it’s numbness and tingling, it really could be anything controlled by the nervous system.”

ii. * Let them know what you’re looking for before you find it, then tell them you found it (with evidence when necessary)

e. Show them a chart/diagram to pre-frame what you are looking for with the exam.
i. “Now let’s go do some (special) testing to see if that’s actually what’s happening”.

3. Examination

a. Sequence your exam in terms of convenience and speed. Keep the conversation going but not at the expense of efficiency. Use lay terms when letting them know what you are testing.
i. “Now we’re going to test your eyes. Now we’ll test a few nerves.”

4. Report of Findings

a. Based on history and exam, we did find evidence of subluxation.
i. What is wrong with me?
   Preliminary diagnosis – be sure to communicate in terms the patient will understand
   Chief complaint/diagnosis could be related to subluxation

ii. How did it get this way?
   Explain the mechanism (subluxation)

iii. Can you help me?
   Yes. Explain chiropractic
   Chiropractic recommendations
   Outline goals for care

iv. How long will it take?
Frequency of care (provide initial two week plan and then provide longer plan at second ROF. Explain that the initial plan is to provide chiropractic care for two weeks, then you will follow up with additional/supportive plans)

v. How much will it cost?
   Outline costs
   Outline commitments (ask for a commitment to the plan provided)

b. Provide the Informed Consent and ensure that the patient signs and dates. One is provided at the initial ROF and an Update is provided at the second ROF. The second informed consent is valid for one year by Health Center policy

**INFORMED CONSENT**

In the state of California, Informed Consent must be completed by a licensed chiropractor. The Informed Consent must be obtained prior to carrying out any diagnostic or therapeutic procedures on patients. The Informed Consent form is signed by the patient after the ROF and before the first adjustment. Informed Consent Instructions:

The Informed Consent to Chiropractic Care form is to be used on every new patient at the time of the Report of Findings BEFORE care is provided to the patient. The faculty must mark on the form the procedure(s) that are part of the approved care plan. The patient must read the Informed Consent form and a licensed Health Center faculty doctor must verbally explain the risks and benefits of chiropractic care to the patient. The doctor should disclose to the patient all significant clinical information available at the time in order to give the patient the clearest picture of the proposed procedure, associated risks, benefits, and/or alternative treatments, The patient checks the box indicating that they have read or had read to them the Consent form and then both the patient and doctor print and sign their name, once the patient understands and has had their questions answered. The intern checks off procedures or modalities he/ she is including in the case management plan and explains these to the patient. The patient then initials each of these in agreement.

In an Acute Care Case, the form MUST be read, explained, and signed BEFORE any care is provided. Any licensed Health Center faculty doctor can explain and sign the form; it can be a covering faculty doctor in the absence of the assigned faculty mentor. Once the Informed Consent form is signed, then a copy is made. The original goes in the file behind the Faculty Notes page and the copy is given to the patient. If the care plan is changed to include any procedures that were not checked on the original Informed Consent form, then that procedure must be marked, initialed, and dated on the form behind the Faculty Notes page. The risks and benefits of that procedure must be explained to the patient; the form must be resigned and dated by the patient and faculty, and a copy given to the patient.
Patient Visit Slip

This form is the single most important form to ensure accurate patient financial accounting and intern credits!

The Health Center receptionist will print a visit slip for each patient. The visit slip includes the patient’s name and account number, the date, the intern of record and doc code, the current diagnosis, etc. This information is essential to the record-keeping program of the Health Center. It creates accurate billing records, patient statistics, and tracks graduation credits.

Health Center faculty and staff are given authority to indicate which procedures have been provided. This ensures that the patient is billed appropriately, and the intern’s credits are correctly recorded. The visit slip is printed in duplicate. The visit slip is to be returned to the Chiropractic Assistant at the end of the patient visit. The intern must keep the pink copy for credit. Visit slips should always be turned in at the end of the day even if an adjustment was not performed. Patients may request a printed receipt as evidence of the visit, procedures, and charges.

Office Visit/Adjustment Procedure

The patient checks in and receives a Patient Visit Slip (also called Visit Slip). Student patients may not check in at the front desk until 12:20 but their intern may sign up in advance (before 11:30) to have a visit slip pre-printed.

The intern checks out the patient’s file and any other appropriate records.
The intern greets and assists the patient to the appropriate area.
If the re-evaluation is due or past due, intern must obtain permission to adjust the patient from faculty before starting the SOAP note.
The intern provides the examination procedures appropriate to the subjective, objective, assessment procedure and completes a thorough write up in the patient record.
The intern requests approval of their care plan for the day by their mentor. In the Student Health Center approval is made by the assigned faculty.
Care is approved by the faculty doctor initialing the patient file on the S.OA.P. note for that date. The faculty doctor initials the Patient Visit Slip once care has been provided.
When the visit is concluded, the patient presents to the cashier with the visit slip for payment and processing. The patient may check his or her financial account and make any appropriate payments at this time.
All patient care must be performed in the Health Center. Patients cannot be taken to the Fitness Center for exercise instruction.
EQUIPMENT (Sample – on Canvas)

RE-EVALUATION EXAM   (Sample – on Canvas)
Periodic re-evaluation exams are performed to track the patient’s response to care. When a re-evaluation is performed the same day an adjustment is given, the re-evaluation is completed before the adjustment. There are 2 types of re-evaluation exams, a progress re-evaluation and a re-evaluation with new a complaint.

Progress Re-evaluations (Sample – on Canvas)
The completed exam, updated PDCS and a copy of visit slip are all required before the file can be dropped into the re-evaluation tray in the Records Room. DO NOT take a re-evaluation PDCS to the mentor unless it is a Medicare file or includes a new complaint. Medicare (blue) files must have a PDCS completed with practice mentors.

Re-eval with New Complaint (Sample – on Canvas)
Any time a patient reports a new complaint or new injury, a History of New Complaint and a focused exam must be completed. If the patient’s re-evaluation date will soon expire or if the patient reports the new complaint at the time of the re-evaluation, or if the new injury or complaint affects the previous complaint, the intern should complete both the yellow re-evaluation form and the blue history of a new complaint with appropriate OATS and focused exam. The mentor makes the decision regarding which focused exams to do. The procedure is as follows:

All patient procedures prior to date of the re-evaluation are the same as written under Progress Re-evals.
The intern completes the yellow re-evaluation form, the blue history form and new OATS, which are found on the form shelves within the student computer areas on floors one and two, and on the forms wall in the student clinic, or with the mentor. Intern obtains faculty signature on back of the blue history form.
The intern completes a focused exam on the area of the new complaint and has the Health Center faculty review when completed. At this time the Health Center faculty signs the yellow re-eval form, the exam form, and the visit slip.
New X-rays and labs are authorized and ordered as appropriate.
The patient can be released at this point.
The intern completes a new PDCS form.
All re-evaluations with a new complaint require that the mentor review the updated PDCS form.

If the patient reports a new complaint or new injury shortly after their progress re-evaluation has been done, it may only be necessary that the intern complete the blue history, with appropriate OATS and exam. The procedure is the same as above with the exception of the yellow form. The re-evaluation date given on the updated PDCS should be the same as the old
re-evaluation date if appropriate. The patient is to be charged for a re-evaluation in either case.

**Give us a Grade** (Sample – on Canvas)
Intern has the patient fill out this Patient Survey Form and then brings it to the Front Desk. The patient should fill this out while the intern goes to get faculty signatures.

**In-activations**
There are two (2) ways in which a patient file is inactivated:

- The intern goes to the Health Center mentor to request that the file be inactivated.
- More than one year has elapsed since the patient’s last visit

In the first instance, the intern enters the reason for the inactivation on the last SOAP note form and then brings the file and the inactivation sheet to their mentor. In the second instance, the patient’s records are pulled from the active file cabinet, appropriately documented, and archived by the Records Room staff.

The fact that a patient file becomes automatically inactive due to inactivity does not absolve the intern of the responsibility to have formally inactivated the file nor of their responsibilities to the patient, the patient’s records, or to the Health Center. Inactive records are archived for 7 years and are retrievable when necessary. Interns checking out of the Health Center must transfer or inactivate all patient files with their mentor. An LCCW student’s patient file cannot be inactivated until their graduation.

**CHANGE OF TECHNIQUE**
In order to change the technique or care plan for any patient, the intern must consult with the mentor and complete an updated PDCS. Until the new care plan is approved, only the approved care plan, frequency; duration may be performed on the patient. Once the care plan has been updated, an updated Informed Consent must be delivered by a HC faculty and signed by the patient.

**MEDICARE GUIDELINES** (Sample – on Canvas)

**PATIENT REFERRAL** (Sample – on Canvas)
Patient Referrals must be completed with Health Center faculty supervision. All patients, who require a referral for immediate emergency care, additional examination/ testing, or co-management, are given a referral form with the findings indicating the need for management outside of, or in addition to chiropractic care. The form is signed by the intern, the patient, and a Health Center Faculty Doctor. The patient receives the original and copies are placed in the patient file and sent to the intern’s Mentor, as well as to the Compliance Officer.
Once a month, the Compliance Officer will audit the referral files to determine if patients followed through with the recommended referrals. If nothing is documented in the file, then a referral follow up form is sent to the Mentor, who then meets with the intern to determine what has been completed and documented in the SOAP notes, and what may need to be followed up on.

Clinical Laboratory Requests
Lab Requests:
  • Intern fills out the LCCW lab request form; the practice mentor will review and sign it.
    o The Faculty Mentor has access to order the labs online. See your Mentor to access online lab orders.
  • Decide if the patient will be private pay (using the LAP draw and test fees) or if lab will bill insurance (use the comprehensive fee schedule).
  • Patient is given the requisition EBL form and a copy of the Lab Corp locations. The patient can also reference www.labcop.com for phone numbers and other locations. The patient will fill out their name and address on the form.
  • Patient will go to the lab and have their blood drawn. Please let the patient know if they will be fasting or not prior to the blood test.
  • Lap Corp will fax the Health Center Specialist the results, who will review and bring to the Records Room to be filed into the patient’s file.
  • Intern reviews the results and writes the findings and their interpretation of these findings on the bottom the request form
  • Intern schedules a 15 minute CMR appointment with floor faculty (cannot schedule during weeks three through six).
  • If faculty believe the lab results warrant a referral, the patient referral form is completed with and signed by the patient.
  • A copy of the referral is kept in the patient file behind the faculty notes page.
  • The intern will follow up with the patient to ensure he/she has visited with their MD and treatment was provided.
  • The lab results get filed on top of x-ray findings in the patient file.

Clinical laboratory credits are also given on laboratory tests ordered through Lab Corp or received from an outside source, on the intern’s assigned patient. These lab results and/or their credits are not transferable to another intern. Credit is given at the time of CMR evaluation.

Lab Request Form (Sample – on Canvas)
This form is to be used when an intern requests lab work to be done on a patient. The intern is not allowed to request lab work that has not been pre-approved by a HC Faculty. After signing this form, the faculty will authorize the release of the Lab Requisition book from the Records Room. Space is provided on the form for a brief narrative concerning the results. The results of
these procedures are to be taken through CMR within two (2) weeks from the date the lab work is received.

OUTCOME ASSESSMENT TOOLS AND SCREENS (OATS)

Functional assessment questionnaires give the interns and their Mentors qualitative data regarding the patients’ condition(s) that is tracked over the course of their care plan to assess progress or lack thereof. It provides objective data based on the patient’s subjective reports. The results of these OATS provide qualitative data showing how care impacts the patients’ lives in day-to-day functions. The following are evidence-based measurement tools that have been validated by outside research.

The following OATS will be available for use in the Health Center as appropriate:

All patients

**RAND-36 (Sample on Canvas)**

RAND-36 will be used as our Quality of Life (QOL) measurement tool applicable to ALL patients not simply our Wellness Patients. The RAND-36 will be posted to our website to be completed by our patients at Initial intake.

The RAND-36 will be completed annually.

**McGill Pain Questionnaire** (short form) with a pain diagram, will be used for the patient to mark his/her area(s) of complaint(s) (Sample – on Canvas). *Given at initial and Re-eval exams to track along with an accompanying functional OAT

**Cephalgia** (Sample – on Canvas)

Headache Disability Index (HDI) for patients complaining of headaches,

**Migraine (Sample – on Canvas)**

Migraine Disability Assessment Questionnaire (MIDAS) for patients complaining of migraine headaches

**Peds MIDAS** for children and youth ages 4-17 complaining of migraine headaches (Sample – on Canvas)

**Cervical complaint (or cervicalgia)** (Sample – on Canvas)

Neck Disability Index (NDI) for patients suffering from neck pain or whiplash.

**General pain or Thoracic spine complaint** (Sample – on Canvas)

Pain Disability Index for patients whose only pain is in the mid-back, and/or generalized pain (as in fibromyalgia)
Lumbopelvic complaint  (Sample – on Canvas)
Roland Morris Disability Questionnaire for patients complaining of low back complaints.

Upper Extremity complaint
Disabilities of the Arm, Shoulder and Hand Questionnaire (DASH) for patients complaining of upper extremity complaints (Sample – on Canvas)

Lower Extremity complaint
Lower Extremity Functional Scale (LEFS) for patients complaining of lower extremity complaints (Sample – on Canvas)

If Depression or Anxiety is checked by the patient on the Wellness Questionnaire.
Patient Health Questionnaire (PHQ-9) will be used for patients admitting to depression on the Wellness Questionnaire who are not currently being medically managed. (Sample – on Canvas)

General Anxiety Disorder Scale (GAD-7) will be used for patients admitting to anxiety on the Wellness Questionnaire who are not currently being medically managed. (Sample – on Canvas)

General Instructions:
• Patients (except asymptomatic patients) will mark ALL complaints on the initial intake paperwork documenting all areas of complaint on the Pain Diagram.
• All patients (except asymptomatic patients) will fill out the McGill Pain Questionnaire at the initial exam and each re-eval exam for the chief complaint only.
• In addition, patients will need to fill out at a functional OATS form pertaining to their area of chief complaint.

Interns may choose to have the patient fill out more than one McGill Pain Questionnaire or functional OATS form.
The OATS are listed on the Case History Diagnosis Worksheet. Interns and their Mentors will have the patient complete the appropriate OATS prior to doing the patient examinations.
*These OATS will take the place of the General Pain and Disability Index Questionnaire (GPDIQ)

Procedures for Anxiety/Depression Response on Patient Questionnaire:
When a patient is experiencing anxiety or depression currently:
• Ask if they are currently under treatment (meds or therapy). Ask if they feel like current treatment is working. If no treatment, or treatment is not working:
• Have patient fill out the PHQ-9/GAD-7.
• If score is above 10, give patient a list of Mental Health Referrals.
• If score is above 5, include walking or other aerobic exercise in management plan. Also, consider nutritional component.
• Make sure to fill out referral form if giving Mental Health Referral list.
information and follow-up in the SOAP notes.

- Have patient fill out the PHQ-9/GAD-7 at least once a month until it is below a 5.

**Contraindications/Red Dot Procedures**

A ‘red dot’ is placed outside of a patient file, and in the Faculty Notes page to alert both interns and faculty that some comment or contraindication to patient care exists. The contraindications/condition will be explained in the Faculty Notes and signified with a red dot. A red dot can only be removed by the doctor who placed the red dot.

**Examination: Gynecological/Proctological Exams**

Whether requested by the patient or deemed necessary by the intern, the interns of LCCW Health Center do not provide female breast or vaginal examinations and/or male prostate examinations. The intern is to consult with the mentor for the proper procedure for referral.

**PATIENT EDUCATION**

See ROF above.

Since an understanding of Chiropractic and its relationship to their condition is important for patients to fully participate in their care, it is the policy of the Health Center that all patients be encouraged to attend patient education lectures available through the Health Center. This activity fosters long-term patient education. There will be opportunities to lead and assist in Chiropractic New Patient courses that new patients may attend, to participate in Community Health and Corporate Talks, as well as attending Chamber of Commerce meetings given on and off campus. Please see your mentor for information regarding marketing events.

**Weekly Patient Education Classes**

The Life West Health Center provides weekly opportunities for standard patient education courses. The course outline is set by the Health Center and is available for presentation in power point from the outreach coordinator.

To participate, see the outreach coordinator.

Patients should all be encouraged to attend patient a patient education course within two weeks of initiating care and should bring family or another guest. Guests will be offered a free consultation and exam if interested in chiropractic care.

The outreach coordinator keeps a schedule of classes, the power point presentation and instructions for the course.
**OUTREACH**

- Each intern must participate in 2 Outreach activities in order to graduate.
- Your mentor will help you prepare for self-procured events and to assist in the acquisition of events.
- All events and activities must be approved through your Mentor and/or the Executive Assistant to the VP of Clinical Operations.
- Prior to reaching out to an opportunity, you must receive approval from the Office of the Executive Assistant to the VP of Clinical Operations.
- All applications and fees associated with events must be submitted and approved prior to the event to the office of the Executive Assistant to the VP of Clinical Operations, including events and opportunities you set up yourself.
- Interns will not be reimbursed for fees they have paid in advance.
- Forms for completion of an outreach event are available on Canvas and must be signed off for approval by either your Practice Mentor or the office of the Executive Assistant to the VP of clinical Operations before being turned in for credit.

**Business Cards**

An LCCW Health Center standard business card is established for the use of all interns in the LCCW Health Center. It may be ordered once the intern is drafted into a practice group (i.e. Week 5 of their Student Clinic 2 quarter). There are blank cards available at the front desk while interns wait for their cards to be shipped or as an alternative to personalized cards. These blank cards are available at no cost to the Interns. No other business card will be used. Cards can be ordered on the college website: http://lifewest.edu/about/monette-h-pierce-health-center/chiropractic-intern-business-card-order-form/. All cards include your Mentor's name as the licensed chiropractor, the College Health Center address, phone, and an appointment calendar and business hours. The intern is identified as a chiropractic intern. Use of other licenses or certificates (i.e. massage therapy, acupuncture, athletic trainer MD, DO, etc.) cannot be used on the Health Center business card. Please note that the cost for 1000 cards with shipping is a flat rate of $40. This will be deducted by the Life West Business Office from your financial aid.

**Advertising**

- Interns are not allowed to advertise in any way other than one-on-one personal marketing and participation in approved marketing activities.
- Any literature to be handed out by interns must first be approved by the office of Vice President of Clinical Operations. All literature must include the LCCW Health Center name, address, and phone number, and the Mentor’s name and credentials. There can
be no intern information or personal likeness on literature other than business cards

- Only approved business cards may be used.
- Any marketing activity, either on or off campus, must be preauthorized by the interns’ Mentor and/or the office of the Vice President of Clinical Operations.
- Interns cannot in any way promote themselves as “licensed.” This includes the terms doctor, Dr., D.C., doctor of chiropractic, chiropractor, etc. on business cards, phone, or cell phone answering systems, personal web pages, email addresses, social networking sites, or any other media. The acceptable terminology is Chiropractic Intern, Intern, Senior Intern, Student Intern, and Senior Chiropractic Intern.
- Interns cannot use other degrees, licenses, certifications, or credentials on any published materials in conjunction with the college, the Health Center, or the chiropractic internship. These include but are not limited to massage therapy, acupuncture, or nutrition credentials, personal training, or any other health care related field.
- All advertising efforts must be approved by the office of the Vice President of Clinical Operations before initiating the effort or event.

Social Media Advertising

- As stated above, Interns are only allowed to participate in one on one personal marketing activities approved by the office of the Vice President of Clinical Operations.
- No social media advertising or marketing is to be used by interns.
- Interns may present their ideas or suggestions to the Vice President of Clinical Operations for use on the LCCW Health Center social media platforms.
- The public may report inappropriate conduct to the state board if your profile isn’t professional and you identify yourself as a Chiropractor or Chiropractic Student. Please note: anything you post, tweet, or reference may be used against you in a legal case, so clean it up now!
- Be cautious of what you like or share because it will show up on other’s newsfeeds.
- Do not post photos of patients
- Do not post photos of yourself adjusting or providing care
- Do not make claims regarding efficacy of care.
- Do not post anything regarding the Life West HC; always defer to the Health Center website and social media platforms.
- If a patient requests that a picture be taken of them the picture must only include the patient, the intern cannot be in the picture.
- The picture must be taken with the patient’s camera/camera phone. The intern may not use their own camera to take the picture.
- Students must ensure that there is no potential PHI (protected health care information) in the background of the picture. This would include computer screens or open files.
- Pictures may be taken with Mentor approval only.
INTERN SUBSTITUTION PROCEDURE

One-Time-Only (OTO) Care

One-Time-Only adjustment protocols include:

One-Time-Only (OTO) Appropriate and effective patient care is our primary objective. When the patient’s usual intern is unavailable to the patient on a given day, it is expected that the substituting intern will become completely familiar with the patient case prior to administering care. One-Time-Only adjustment protocols include:

• The intern is to take the patient file and visit slip to the Mentor. The file will be reviewed and documented appropriately. The patient file is to be reviewed noting the following:
  • Restrictions and/or contraindications remarks of the Health Center faculty doctor(s)
  • Review of the case history and examination findings
  • Review of the S.O.A.P. notes of previous care
  • Review of all laboratory and x-ray reports
  • The Mentor needs to approve the OTO visit prior to the intern writing up the S.O.A.P. notes
  • The substituting intern must follow the approved case management plan.
  • The intern is to line through/cross out the name of the intern of record on the top of the visit slip and write their name and doc code. The faculty will initial the change.
  • No patient may be seen more than three (3) times in a quarter by an intern other than the intern of record unless otherwise approved by the Mentor and documented in the faculty notes.
    o In the extended absence of an intern of record, the protocols for vacation relief should be followed. (see below).
  • No OTO's will be allowed on files that are past due for re-evaluation except for acute care protocol.
  • No credit for OTO's on student category patients
  • No OTO's are allowed under vacation relief protocol.
  • There are no OTO's allowed on new patients who have not had their initial PDCS completed yet

Vacation/Vacation Relief Process

All interns must discuss their vacation with their mentor in advance. This includes any time taken during academic breaks.
The intern is responsible to:
• Make sure the re-eval dates are current through the vacation period. Credit may not be
given to the relief intern if the file is not current.
• Give all patients the dates that the intern of record will be gone.
• Give all patients the names and contact information of other intern(s) who will care for
them while their intern of record is gone.
• Make sure the other interns are available. Give them the names of the patients.
• Discuss any special considerations of the patients’ care with the other intern(s)
• Appointments must be made and verified with the substitute intern(s).
• Mentor writes the substitute intern’s name and time they will cover on the Faculty
Notes page.
• No credit for OTO’s will be given under vacation relief protocol.
• Both interns need to be present when assigning vacation relief duty.
• Patient must be assigned to a vacation relief intern. If this is not done, adjustment
credit will be taken from the intern of record when they return from vacation and the
patient may be transferred to another intern.

• Student Clinic 2 interns will only be available for vacation relief once they have completed
all student clinic 2 requirements.

Co-Management

Procedures for Co-Management:
• Mentors will make the decision regarding how all cases will be managed
• Co management must be approved BEFORE any activity by interns. No credit will be
given for care rendered prior to approval.

Co-management - Extremity Concern
In cases where the primary intern has not completed the extremity coursework (eg. SC-
II) and the patient has an extremity concern, the case can be co-managed with an
intern who will care solely for the extremity concern
If not co-managed, the mentor can provide care for the extremity concern

Senior Intern Graduating – Patient Transferring to a New Intern
In cases where it is deemed appropriate, the mentor can extend the Re-eval date and in
lieu of the re-eval exam, the new intern will complete a “transfer exam”
The patient benefits by not having to go through both a re-eval and a transfer exam
back-to-back

PI Cases
A SC-1 student with a PI case will be transferred to a senior intern for management
General
A SC-2/C-1 student requiring mentorship or who would benefit from working with a senior intern on their first case will be assigned to observe care (no co-management credit)

Adjusting
Qualified interns are allowed to adjust in the Health Center under Health Center faculty supervision and under the specific guidelines as described in the Health Center Policies and Procedures Manual. The college will actively pursue sanctions against interns or students found to be adjusting outside the Health Center, or without proper supervision.

WRITING IN THE PATIENT FILE
S.O.A.P. Note Format Guidelines
Required for all LCCW Health Center (HC) Patient Soap notes

SUBJECTIVE:
HC: What was your response to last visit?
Put pt answers in quotes. If pt is NOT symptomatic –then home care and lifestyle should be discussed and documented in the Plan (P) section of the SOAP note.
  • The response to last visit must include more than “good,” “great,” etc.
  • How long was pain absent? What brought the pain back? Is it the same pain?
  • Pattern? Did the pain shift? Is the intensity less? Follow up on activities of daily living and
  • recommendations given last visit (level of compliance) such as exercises, icing, use of a cervical pillow, etc.
  • If there is pain in any area or areas, then include the Visual Analog Scale (VAS) for each area. If the patient has stiffness and/or tightness: No VAS for “stiffness”, “tension”, “tightness” is needed.
  • OPQRST is not necessary for each visit, except when there has been an exacerbation of a complaint already addressed in the history and exam.

Example: “Neck pain from last visit subsided until today, now it is 2/10. I slept better and had more motion in my neck. Today I have pain on the upper right side of my mid-back, 3/10, I’ve been walking 20 min a day as you suggested”.

OBJECTIVE:
Address the whole spine. Include all significant (+) findings as well as (-) findings that are appropriate.
For every segment, including extremities, that you are going to adjust, you need three findings from three different exams. For example, ROM, if decreased in three ranges,
counts as one criterion only. Use the word decreased, restricted or a down arrow to describe ROM findings. Be specific to level and direction:

Example: C3: Decreased lateral flexion on right, decreased right rotation, decreased flexion:
This is one finding from the patient’s segmental ROM exam. You now need two other exam findings to justify the adjustment at C3.

Include “global, or regional” findings, which may be present in addition to specific level findings. Example: Static palp -T4-T8 muscle spasm

Example: “Visual: High R ear, Shldr, Ilium, Static Palp: Edema and T and T fibers Cerv 5-7, Thor 4..Motion Palp: Decreased R Lat Flex and Rt Rot Cerv 5, Decreased Lt rotation, RLF T4, Decreased LLF, Rt Rot L5”

ASSESSMENT:
• Today’s subjective and objective findings should be consistent with the assessment.
• use minimal, slight, moderate, severe based on the VAS score to document severity of symptoms. You do not need to mention chronicity.
• Structural findings, such as DJD, DDD, do not have to be listed.

Example: VSC cervical spine, minimal neck pn, VSC Thoracic spine, slight upper back pain

To be used in Assessment section of SOAP if symptoms of pain are present

Phase of Injury   Onset
Acute   0-72 hours
Subacute  72 hrs-2 weeks
Chronic 2 weeks and beyond

Frequency (Timing – note that these are all “during waking hours”)
Constant: Occurring approximately 90-100% of the time
Frequent: Occurring approximately 75% of the time.
Intermittent: Occurring approximately 50% of the time.
Occasional: Occurring approximately 25% of the time.
Less than Occasional/Seldom/Infrequent (LCCW terms): Occurring <10% of the time.

Intensity (Severity)

Minimal or mild: (LCCW VAS of 1-2) A pain that would constitute an annoyance, but would cause no handicap in the performance of activity.
Slight: (LCCW VAS of 3-4) A pain that could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.
**Moderate:** (LCCW VAS 5-7) A pain that could be tolerated, but would cause a marked handicap in the performance of the activity precipitating the pain.

**Severe:** (LCCW VAS 8-10) A pain that would preclude the activity precipitating the pain.

**PLAN:**
- Technique
- Listing
- Patient Position (supine, prone, knee chest, cervical chair, etc.)
- Doctor set up (knife edge, single hand, double thenar, etc.)
- If PT is going to be used, write what modality and the area it is used on.
- List patient recommendations/homecare if discussed on this visit.
- HC: It is recommended that you have the next scheduled visit already set up and you may note it here as well as on the visit slip.

**OL:** You may list the recommended next visit either to be done in Open Lab or with student pt’s regular intern.

Example: DIV C5 PR seated, DIV T4 PLI-t single hand prone. Next visit in one week. Continue 20 min daily walk.

**POST CHECKS:**
Address what is appropriate based on what you used to determine the subluxation in the first place.
Example: Increased Cervical ROM, Legs even, Muscle tone-same.

**ABBREVIATIONS FOR HEALTH CENTER FILES** (place this information in a table to clean it up)
Writing in the Patient File Abbreviations for Health Center Files
The abbreviations listed below can be used to shorten note- taking in the patient file. Any other personal abbreviations are not acceptable.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm</td>
</tr>
<tr>
<td>abd</td>
<td>abduction</td>
</tr>
<tr>
<td>abn</td>
<td>abnormal</td>
</tr>
<tr>
<td>AC jt</td>
<td>acromioclavicular joint</td>
</tr>
<tr>
<td>add</td>
<td>adduction</td>
</tr>
<tr>
<td>adj</td>
<td>adjustment</td>
</tr>
<tr>
<td>ADLs</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>AHC</td>
<td>Anterior head carriage</td>
</tr>
<tr>
<td>ALLI</td>
<td>Anatomical Leg Length Inequality test</td>
</tr>
<tr>
<td>am</td>
<td>morning</td>
</tr>
<tr>
<td>ant</td>
<td>anterior</td>
</tr>
<tr>
<td>AP</td>
<td>anterior to posterior</td>
</tr>
</tbody>
</table>
AROM  Active range of motion
ASIS  anterior superior iliac spine
B/g  beginning/began
Blk  blocks- used with SOT or CBP
BL  bilateral
CC  chief complaint
C/T  cervicothoracic
CVA  cardiovascular accident
CVJ  costovertebral joint
DJD  degenerative joint disease
E  edema
EENT  eyes, ears, nose, throat
ET  elastic taping
ext  extension
F  fixation
Flx  flexion
FM  Functional Medicine
FS  full spine
FT  Functional Training/Rehab
F/U  follow-up
Fx  fracture
GI  gastrointestinal
GU  genitourinary
GYN  gynecological
H  hypertonic muscles
HA  headache
HBP/HTN  high blood pressure/hypertension
HPI  History of Presenting Illness
Hx  history
IVD  intervertebral disc
KT  kinesiotape
Lt  left
Lab  laboratory
Lat  lateral
LB  low back
LBP  low back pain
LE  lower extremity
lig  ligament
LLF  left lateral flexion
LLLT  low level laser therapy
L/S, L-S  lumbosacral
MFR  myofascial release
MI  myocardial infarction
mm  muscles
MP  motion palpation
MRI  magnetic resonance imaging
MVA  motor vehicle accident
NAD  no abnormality detected
-  Negative
Neg  negative
O/U  overuse
OV  office visit
P-A  posterior to anterior
PERRLA  pupils equal round regular react to light and accommodation
PI  personal injury
palp  palpation
PMS  pre-menstrual syndrome
Pn  pain
Pos or +  positive
prn  as needed
PSIS  posterior superior iliac spine
Pt  patient
PT  physical therapy
q.  every
q.d.  once a day
b.i.d.  twice a day
t.i.d.  three times a day
Rt  right
RA  rheumatoid arthritis
RLF  right lateral flexion
ROM  range of motion
R/O  rule out
ROS  review of systems
ROT  rotation
RSI  repetitive stress injury
RT  Rocktape
SI  sacroiliac
SCM  sternocleidomastoid
SLR  straight leg raise
SMT  spinal manipulative therapy
SP  spinous process
Sx  symptoms
TT  taut and tender
TENS  transcutaneous electrical nerve stimulation
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFM</td>
<td>transverse friction massage</td>
</tr>
<tr>
<td>TMJ</td>
<td>temporo-mandibular joint</td>
</tr>
<tr>
<td>TMD</td>
<td>temporo-mandibular disorder</td>
</tr>
<tr>
<td>TOS</td>
<td>thoracic outlet syndrome</td>
</tr>
<tr>
<td>tp</td>
<td>transverse process</td>
</tr>
<tr>
<td>TP</td>
<td>Trigger Point</td>
</tr>
<tr>
<td>trap</td>
<td>trapezius</td>
</tr>
<tr>
<td>TTT</td>
<td>taut, tender,</td>
</tr>
<tr>
<td>TP</td>
<td>transverse process</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>UA</td>
<td>urinalysis</td>
</tr>
<tr>
<td>UE</td>
<td>upper extremity</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>US</td>
<td>ultrasound</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>VAS</td>
<td>visual analog scale</td>
</tr>
<tr>
<td>VSC</td>
<td>vertebral subluxation complex/subluxation</td>
</tr>
<tr>
<td>WB</td>
<td>weight bearing</td>
</tr>
<tr>
<td>wk</td>
<td>week</td>
</tr>
<tr>
<td>/w</td>
<td>per week</td>
</tr>
<tr>
<td>w/</td>
<td>with</td>
</tr>
<tr>
<td>c</td>
<td>without</td>
</tr>
<tr>
<td>WNL</td>
<td>within normal limits</td>
</tr>
<tr>
<td>Ṡ</td>
<td>every</td>
</tr>
<tr>
<td>ā</td>
<td>before_</td>
</tr>
<tr>
<td>P</td>
<td>after</td>
</tr>
</tbody>
</table>

**Technique Abbreviations:**

ACT  Activator
ADVO Advanced Orthogonal
BLk Blocks (used according to listing)
BLR  Blair
CBP  Chiropractic Biophysics
DIV  Diversified
DROP Drop Table
EPIC Evolutionary Percussion Instrument Correction
GON  Gonstead
Non-core Techniques
NUC  NUCCA National Upper Cervical Chiropractic Association
SOT  Sacral Occipital Technique
TOG  Toggle
Additional symbols:

< Less than
>
Greater than
→ causing, leading to, producing
↑ increased, increasing
↓ decreased, decreasing
≈ Approximately
Section 3

Health Center Manual
Health Center Supplemental Information

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center's policies and procedures as needed.
Public Health Recommendations

In an effort to keep Staph aureus/MRSA out of the Health Center, the following procedures apply. If a patient, intern, faculty or staff has any soft tissue infection, cut or scrape that is oozing, hot to the touch, or swelling then the infection is spreading. The person needs to go to urgent care. It is the intern’s responsibility to wipe and disinfect any areas that the patient may have exposed to a virus or bacteria. If the cut is bandaged then the risk is minimized.

Interns are not tested for TB before they enter their internship at the Health Center. If a patient is coughing up sputum with blood, they need to head to an Emergency Department. This is not a case that can be seen or treated in the Life West Health Center. This may be a sign or presenting symptom of TB/ Klebsiealla pneumoniae, or lung cancer. Anyone (patients, interns, faculty or staff) that has a fever at 100 or higher should stay home particularly if it’s accompanied by an upper respiratory disease.

Interns must always be vigilant for signs and symptoms of the following:

- Influenza - abrupt onset of fever, lethargy, difficulty eating, etc.
- Any vaccine preventable disease: mumps/measles/rubella/chickenpox - all appear as a rash (rubella is a swollen throat).
- Meningitis - very high fever, stiff neck where patient can barely turn their head, photosensitivity, headache, nausea, lethargy.

Crime Prevention

The Life West Office of Campus Enhancement has always taken the position that it is best to inform students and employees of unsafe practices and conditions. Each September, campus crime statistics are posted on the College’s website and are available to the College community and to prospective students. The theft of any item, no matter how insignificant it may seem, should be reported to the Student Life Office immediately.

Please see the assistant to the Vice President of Clinical Operations or Student Life to obtain and fill out an incident report when a theft occurs. Please make sure that you lock your vehicle, close your windows, and keep valuables out of sight as a preventative measure.

Emergency Procedures

In the event an emergency arises in the Health Center (i.e. heart attack, seizure, personal injury, etc.), it is mandatory that the following procedure be followed:

- The intern is to stay with the patient
- A Health Center faculty doctor will take appropriate first aid measures
- A Health Center faculty doctor will authorize a call to 911, if necessary
Standard first aid kits are placed at key Health Center locations. Become familiar with these locations. There is an AED (Automated External Defibrillator) located behind the front desk.

Once the immediate crisis has passed, write a detailed report of the incident as it occurred in the notes, complete an Incident Report form and have a Health Center faculty doctor initial both. Include these forms in the patient’s file and forward a copy to the Vice President of Clinical Operations. Complete any other necessary forms so the patient may be referred properly, if needed.

In accordance with the college’s Injury and Illness Prevention Program, all non-ambulatory patients must be seen downstairs in the Health Center. Practice Mentors will come downstairs to observe patient care. The only exception to this is patients seen in the Imaging Department. Do NOT use the elevator in the event of an emergency.

**Personal Property**

Life Chiropractic College West is not responsible for the personal property of the students (e.g., books, supplies, laptops, equipment and clothing). Students are encouraged to place their names & student ID numbers on all items of value and record and secure equipment serial numbers. Students should review their personal property/homeowners/renters and automobile comprehensive insurance policies to determine whether valuable equipment (such as laptops, diagnostic or adjusting equipment) would be covered in the event of theft or loss.

**Campus Law Enforcement**

The Life West Office of Campus Enhancement is not a law enforcement agency, and therefore, does not make arrests. While each student, employee and visitor is subject to the lawful request and direction of a campus security officer, arrests, if necessary, are affected through the local jurisdiction by use of arrest warrants.

**Equipment**

Consideration of the next intern’s use of the equipment is necessary.

- Immediately report any broken or damaged equipment to the Health Center faculty. Work order forms are available in all faculty offices and should be submitted to the Front Desk staff. Be as specific as possible about the problem and the location (room or cubicle number, etc).
- All rooms are to be left in a neat and orderly fashion
- Activator tables are to be returned to their horizontal position.
- Always return special equipment, such as SOT blocks and physical therapy equipment, to their proper storage area.
- Watch carefully for hands, feet, jewelry, or other items that might get caught in moving equipment.
- Use caution when children are in the room. Keep potentially dangerous equipment out of the
reach of children, and keep children away from all equipment for their safety. Clean the face area of each table after each use with sanitizing wipes provided in each room.

Abuse Reporting

Child, Elder, or Dependent Adult Abuse - Reporting is Mandatory
When an intern suspects child (under 18 years), elder (65+ years), or dependent adult (18-64) abuse, the intern is to tell the patient (and caregiver) that the intern needs help with patient assessment. The intern is to go to his or her mentor.
The Mentor will:

- Meet the patient
- Examine and ask questions necessary (caregiver should remain in the room)
- Decide if any x-rays are necessary
- Decide if the case needs to be reported to the appropriate authorities. If the case needs to be reported, follow these steps:
  - Notify the Vice President of Clinical Operations
  - Phone the appropriate agency immediately.
  - Write a report within 24 hours: Reporting of suspected child, elder, or dependent adult abuse is the legal responsibility of all health care professionals and must be done within 24 hours of the observation of evidence. All full time Health Center Faculty are appointed this responsibility in the Health Center and will report and document the suspicion within 24 hours to:
    Hayward Police Department 300 West Winton Avenue Hayward, CA 94544 (510) 293-7125 or (510) 293-7048
    Alameda County Emergency Response Unit 24 hour hotline (510) 259-1800
    Or Alameda County Child Abuse Prevention Council PO Box 7080 Oakland, CA 94612
  - To report elder or dependent adult abuse: Alameda County Adult Protective Services 24 hour hotline (510) 577-1900
  - If domestic violence/spousal abuse is suspected, the following hotlines are available to the patient:
    - (Safe Alternatives to Violent Environments) Hotline: (510) 794-6055 - Alameda County Call the National Domestic Violence Hotline: 1 800 799-7233 or 1 800 787-3224
Call 911 if you are in immediate danger.

Medicare Guidelines
Federal Medicare guidelines require that the chiropractor is limited to the use of specific identifying codes, procedures, and terminology in order to justify and expedite reimbursement for chiropractic services. When completing the diagnosis for a Medicare patient, the following guidelines should be used:

- Coverage of chiropractic service is specifically limited to treatment by means of manual
manipulation, i.e., by use of the hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

- No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services.
- The patient must have significant health problems in the form of neuro-musculoskeletal condition(s) necessitating care, and the adjustment rendered must have a direct therapeutic relationship to the patient’s condition.
- Medicare coverage is specifically limited to the correction of subluxation, by means of manual manipulation of the spine. X-rays are not covered, nor are such services as physical therapy or supports. (See “Medicare Patient” for additional information). All Medicare patients require the direct supervision of a qualified faculty member.
- Only a licensed chiropractor (Health Center Faculty) can adjust the area of complaint.
- Always work with the faculty mentor to ensure the file is complete and that the care provided meets Medicare requirements.
- CAN WE LINK LCD?
  Patient’s file should be blue.

**Children**

Children of patients are to be supervised by their parent(s) or guardian(s) at all times.

Children of interns are not allowed in the Health Center while their parents are performing Health Center business of any kind. This includes patient care, CMRs and file work.

**Communication Methods**

**CANVAS**

Please enroll and visit the Intern Canvas page at https://lifewest.instructure.com/enroll/7MYEHL. You will be responsible for this information.

**Email**

Life West Student Email - first initial + last name@college.lifewest.edu. Important updates will be emailed to you, so keep checking your email.

The Health Center uses the intern’s college email for dissemination of all updates and notifications. This may include changes to Health Center policies and procedures.

The LCCW Health Center internal communications are accomplished via text messaging through the intern’s personal cell phone. It is required that all interns provide their cell phone account information (this is usually collected during the Student Clinic 1 class).
After a patient checks in at the front desk, the intern will be informed via text message that the patient has arrived. If you do not respond, your mentor will be contacted. Administrative offices in the Health Center also use this system to contact interns.

**Calendar**

All student and outpatient exams, x-ray appointments, office visits, CMR’s and Report of Findings should be scheduled on the Mind Body calendar under your name. To access, go to www.MindBodyonline.com, and under Find Your Site, search for Life Chiropractic College West and log in. You may also use the Mindbody EXPRESS App.

**Visit Slip Procedures and Computer Functions**

The LCCW Health Center maintains the financial accounting and patient management functions by computer. The basic functions of the computer are as follows:

Assignment of patient accounting and file number and all appropriate personal information is entered into the system to accommodate appropriate legal aspects, insurance billing, and patient management. The system’s ability to handle this information is dependent upon the accurate completion and handling of the Patient Visit Slip. It is the intern’s responsibility to see that documentation is completed properly. The Visit Slips require authorized Health Center Faculty signatures to be approved for computer entry.

All patient financial accounting and record keeping is documented via the intern Doc Code. This code must be clearly printed on all credit or Patient Visit slips. Interns are responsible for keeping their (pink) copy of the visit slip for credit verification.

No adjustment credit is given if the visit slip is NOT turned in that day, or is turned in after 6:45 on Monday through Thursday or after 5:45 PM on Fridays!. Only the Vice President of Clinical Operations can authorize any changes to the visit slip once it has been turned in. Supplemental instruction concerning the Health Center computer system is provided as new programs are instituted or upgraded or deleted.

**Community Benefits Program Procedures**

Since our mission at Life Chiropractic College West is to give, to love, and to serve, participation in the Community Benefits Program is available to those patients that qualify financially. The patient will count as one courtesy patient. All other policies and procedures of the Life West Health Center apply.

If the person is living in any kind of shelter, a letter from the Lead Counselor or House Manager of that shelter on the shelter’s letterhead is all that is required to begin care in the community benefits program. If the patient needs to be qualified for community benefits care based on financial need, our Customer Service Manager should be contacted to determine what documents they need to bring in to qualify. The Health Center has the right to refuse care to patients who do not
bring in the required documents. Under no circumstances is the intern allowed to intervene in the qualification process or discuss the financial status of the patient.

So that we can best serve the community and patients who have a financial and health care crisis, Community Benefits status is given for 180 days. The patient is required to be an active participant in their care which speeds up recovery and healing. We are expecting that the patient’s health, function, and vitality will improve tremendously after 6 months of consistent care. At this point, the patient will be expected to pay regular prices if they wish to continue care.

HIPAA

HIPAA (an acronym for the Health Insurance Portability and Accountability Act of 1996) is a federal law that establishes rules for managing Protected Health Information (PHI) (learn more about PHI here: https://www.hhs.gov/answers/hipaa/what-is-phi/index.html) throughout the United States. Although states may adopt stricter confidentiality rules, HIPAA sets the minimum standards and protections for patient privacy. HIPAA's Privacy Rule and Security Rule must be followed by all "covered entities." Covered entities include any person or business that provides, bills, or receives payment for medical care, including:
- health care providers
- clearinghouses that process (change the format of) medical information
- health plans and health insurance issuers

The Privacy Rule protects health information from the time a record is created (or the information is revealed) to the time it’s destroyed. Generally, covered entities and business associates may not use or release an individual's medical information unless the Privacy Rule expressly permits it, or the individual authorizes it. When medical information may be shared, the Privacy Rule strictly limits the amount of information that may be provided.

You can find a detailed description of the privacy rule here: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

Similar to the Privacy Rule, the Security Rule balances protection of PHI shared or stored via electronic means, with the need to access records to ensure quality medical care. While the Privacy Rule controls the use and disclosure of PHI, the HIPAA Security Rule prevents unauthorized access to electronic medical data. The HIPAA Security Rule is designed to secure Electronic Protected Health Information (E-PHI) from disclosure, alteration, or loss, and establish standards for electronic security.

You can find a detailed description of the privacy rule here: https://www.hhs.gov/hipaa/for-professionals/security/index.html

Compliance Officer/Security Officer: Ryan Odell Privacy Officer: Ryan Odell

How is protection achieved?
- Training of staff/faculty/interns
- All staff/faculty/interns sign confidentiality agreements
- Physical security measures (such as: plexiglas in Records Room, Records Room door being locked.)
• Check-out line, log-in codes for computers, and password protected screensavers on all computers containing patient information.)
• Confidentiality agreements with all business associates
• Privacy Notice for all patients and Acknowledgment of Receipt of Privacy Notice
• Student Authorizations for “open room” adjusting and exam courses
• Patients have the right to request Alternative Communications, Restriction of Health Information,
• Complaint Forms, and Accounting of Disclosures. All forms are forwarded to the privacy officer (Compliance Officer).
• Any employee/faculty/intern who is found to breach patient confidentiality will be sent to the privacy officer for sanctions.

• Intern Sanctions for HIPAA Breaches;
• 1st Offense: 3 page paper on HIPAA
• 2nd Offense: 2 week suspension from the Health Center
• Additional Offenses: Health Center Suspension up to Expulsion from the college depending on the severity of the breach(es)

The most common causes for breach of patient confidentiality can be prevented by following these rules:

Keep control of patient files/x-rays at all times: all files/x-rays must be returned at the end of the night; files/x-rays cannot be left unattended; files/x- rays cannot be left with another intern; files/x- rays must be taken into the bathroom stalls with the intern instead of leaving them on the sink; no patient information can be removed from the HC for any purpose (e.g. doing narratives at home); when typing narratives at the HC if you copy to USB drive do not include patient’s name. Any USB or cloud drive with any narrative, even if it doesn’t have the patient’s name, should be password protected.

Do not discuss your patient’s condition out loud while in the waiting room, check-out line, or walking through the halls. Only discuss patient information in the room with the patient or in a room with your mentor. When talking on the phone with your patient, avoid discussing their condition as others might overhear.

Paperwork that contains the patient’s name cannot be discarded into trash or recycling, it must be shredded. There are shredding receptacles throughout the Health Center. If you send information to a printer, you must make sure that you pick up all the pages. If there is a problem with the printer, let your mentor or the records room staff know.

Campus Faculty Consultation Guidelines for HIPAA Compliance

This form must be completed before a non-Health Center faculty doctor may review a patient file and/or make recommendations for care.

Individuals requesting consultation (intern or Mentor) must fill out all the information in the right hand corner of the form and under Purpose of Consultation, Chief Complaint, Pertinent
History, Relevant Physical Exam and other related findings.

The individual seeking the consultation must sign under Requested By in order for this request to be considered and the request has been reviewed and signed by the intern's Mentor.

Once the consultation request has been reviewed and signed it must be placed in the patient's file behind the Faculty Notes page, and be noted in the Faculty Notes. This must be done prior to the scheduling of the Campus Faculty Consultation form may not be removed from the Health Center.

The requesting individual, having followed the above steps, may then set an appointment with the consultant. All appointments must be held within the Health Center.

The consultant must write his/her comments and recommendations on the back of the form signing his/her name, credentials, and the date.

The intern's Mentor then reviews the consultation, and the intern will discuss any PDCS changes to treatment with Mentor doctor.

The results of any consultation must not be discussed with the patient prior to the review by the intern's Mentor and modification of the care plan on the PDCS.

**Personal Appearance and Dress Code**

All interns are expected to be in approved attire while in the Health Center for attending to any Health Center business (i.e. seeing patients, CMRs, faculty advisor meetings, making appointments, checking out files, etc.). Your appearance communicates how you feel about our profession and our institution, and should inspire confidence and communicate respect to patients and their families. Please consider the patient's point of view regarding intern's dress and appearance. The general public expects doctors to have a clean, neat appearance and professional dress.

The following dress code will be strictly enforced. The penalties for an out of appearance from the dress code are:

- **1st infraction:** The intern will be sent home to change and will lose two outpatient adjusting credits. If the intern is only seeing student patients [SCI or SCII], the intern will lose two student adjusting credits.
- **2nd infraction:** The intern will be sent home to change and will lose five outpatient adjusting credits. If the intern is only seeing student patients [SCI or SCII], the intern will lose five student adjusting credits.
- **3rd infraction:** The intern will be sent home and will be immediately suspended from the Health Center for one week.
The intern involved will not be allowed to participate in patient care or any other patient interaction until they meet the appearance and dress code. All Health Center faculty have the authority to enforce the appearance and dress code, with final authority resting with the Vice President of Clinical Operations.

**Appearance/grooming**

- Professional appearance includes regular bathing and clean short fingernails.
- Hair shall be clean and neat. Long hair should be tied back or worn up so that it does not touch the patient.
- Men should be clean-shaven or facial hair neatly trimmed daily.
- Cosmetics if worn should be used in moderation. If nail polish is worn it should be in natural tones of the intern’s flesh color.
- Perfumes, colognes or heavy fragrances must not be worn, as many patients and staff members are sensitive to scents and odors. This includes essential oils.
- Jewelry should be conservative in style and short enough not to dangle in patients or become tangled in equipment. There should be no visible body piercing except for simple earrings and a simple nose ring or stud.
- Tattoos should be conservative or covered. Tattoos that contain potentially offensive content are required to be covered.
- Undergarments (Lingerie, underwear, briefs, bra, binding) must be worn under clothing and must not be visible at any time while performing examinations or providing care.
- All interns may wear a sweater or a sport coat, jacket or blazer for comfort (no outerwear). No athletic wear should be worn, including hats and bands.
- Interns should appear professional and dress should be modest such that chiropractic care can be performed comfortably. Modesty is maintained in all positions required during examination and provision of care.

**Dress Code:**

- Dress pants will be clean, without tears and non-wrinkled. Jeans are not permitted.
- A dress shirt/blouse may be worn and should not be open lower than the joint line of the manubrium and sternum. Buttoned-down shirts should be tucked in. Short sleeve tops may be worn but should cover to the end of the shoulder.
- Approved Life West Health Center Intern tops in black, gray, or green may be worn.
- Ties and Bow ties are permitted, but not necessary.
- A tunic may be worn and must come down to at least half way between the buttock and knee. Pants or solid opaque tights must be worn with the tunic.
Clean shoes with closed toes, closed sides, and closed backs must be worn. Shoes may be either dress or casual, but cannot be an athletic shoe (exception for a solid black athletic shoe). Shoes may have a different colored tread than the main part of the shoe. Socks may not be white or athletic socks.

**Tobacco, Drug and Alcohol Use**
The use of tobacco products (including smokeless) are not allowed on the campus near any of the Health Center doors. Since these products leave a residual smell on the breath and the clothing, interns who wish to smoke should use a breath freshener before resuming patient care of any kind. The residual smell is both offensive and allergenic for many patients. Interns are absolutely prohibited from the use of alcohol or recreational drugs prior to engaging in any health center activities whether on or off campus (such as an outreach opportunity). Refer to the Student Manual for a more complete explanation of the LCCW related policy and procedures.

As a student intern you should be aware of any adverse reaction and side effects if taking certain prescription medications or recreational habits that may impair the intern’s cognitive and/or psychomotor ability to provide quality patient care.

**Health Center ID**
OSHA requires that intern’s Health Center ID must be worn and clearly visible at all times within the Health Center. The only acceptable ID is official LW-HC ID badges that have been produced in the Student Life Office. Business cards may not be used as ID. ID cards should be used on exam room doors or curtains during your patient encounter. Note: If/when you leave the room the ID should come with you. Your ID is not to be used to save a room. ID badges must be worn on your top and placed well above the waist line. NO exceptions. Infractions of the Health Center ID policy will fall under the same penalty as violations to dress code and appearance policy.

**OSHA Standards**
Life Chiropractic College West Health Center adheres to all OSHA standards recommended by the State of California. Exact Policies and Procedures of OSHA can be found in the office of the Vice President of Clinical Operations.

**Preceptorship Program**
It is the intent of the program to offer senior interns, who qualify, a wider and more diverse clinical experience. To that end, the college has established a Preceptorship Program available for periods of three (3) months, on a voluntary basis, with the following conditions:

- The intern must have completed all clinical requirements for graduation with the following exceptions:
  - The hours requirement which may be partially offset at the preceptorship location.
- The intern must have completed all qualitative requirements.
- The intern must be registered for Clinic 3 or 4 and classes from either senior 2 or 3 (if there...
are any onsite classes remaining, the intern may only apply for a local preceptorship. If only online classes remain, then a preceptorship at a distance may be considered)

- The intern must have passed the I.C.E. (Intern Competency Exam) before leaving for the preceptorship
- The intern must, by performance in the Health Center, have shown good character, have attained an acceptable degree of clinical proficiency, and have demonstrated a spirit of cooperation and willingness to learn.
- The intern must be approved for the Program by the Vice President of Clinical Operations. The preceptorship must not interfere with the intern's didactic studies nor delay admission as a candidate for examination by their chosen State Board of Examiners.
- The number of hours served in the preceptorship may be credited as Health Center hours, the hours must be at least 20 hours per week, but may not be in excess of 35 hours weekly as prescribed by the California Board of Chiropractic Examiners.

Only interns enrolled in the Preceptorship Program may check out of the Health Center prior to week 8 of their last quarter enrolled at LCCW.

Program is also available to graduates (See the Preceptor Coordinator)

**Standard Process Procedures**
Interns that have passed both the Basic and Applied Nutrition classes and have completed the Standard Process training are able to recommend Standard Process products in their patient care plans. These interns are identified by their SP pins as well as their technique badge designation.

**The 4 approved supplements for distribution by LCCW Interns include:**
- General Health Supplement pack
- Bone Health Supplement pack
- Adrenal Health Supplement pack
- General Female Endocrine

**Procedures and Guidelines:**
- The intern will utilize the Narrative template and document supporting evidence from the ROS & Wellness questionnaire in order to justify recommendations for supplementation in their care plans.
- Recommended schedule is to match the recommendations on the Standard Process box, package or bottle verbatim. No other recommendations will be approved by any Health Center Faculty.
- The care plan is approved and signed off on the PDCS by the mentor or floor doctor.
- Supplement recommendations need to match with the re-eval schedule. In order for the patient to purchase additional supplements, the re-eval date must be current.
- Prior to the first purchase, the Informed Consent form which includes consent for nutritional and herbal supplementation must be delivered by a Health Center Faculty and
signed by the patient.

- The intern will document in the SOAP note any date of supplement purchase.
- The Health Center Faculty will circle the 100 Misc section of the visit slip and write in the specific product approved for purchase (This verified on the PDCS form).
- The Health Center Faculty will document approval in the Faculty Notes page.
- Interns document follow up with the patient in the SOAP note: patient compliance & associated subjective patient reports.
- The front desk Chiropractic Assistant will collect payment and dispense product based on the HC Faculty Initials & indication of the specific product on the visit slip.
- In the event that we do not have the product in stock, payment may be collected and the product given to the patient on their next scheduled visit or be available for pick up.

**Footlevelers**

A Footlevelers Scan is performed at the Intake exam. The scan is performed at no cost to the patient. Students receive 2 pairs of complementary Footlevelers. They receive their first set of Footlevelers as freshman patients. They receive an additional pair in their Student Clinic 1 quarter as part of their reciprocal patient exam. Outpatient, Outpatient Courtesy and Student Courtesy cost for a pair of Footlevelers is $125. The scanning process and procedure is taught in the classroom so that by Student Clinic 1 interns are prepared to scan their reciprocal patient.
Section 4

Health Center Manual
Health Center Assessments

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
Competency Assessment

The Life West Health Center employs tools for assessment of intern competency in addition to the competency exams explained earlier in this document. These include assessment of Case Management Review (CMR), Report of Findings (ROF) and the Patient Visit Encounter (PVE). The forms (rubrics) used to assess these processes are available on Canvas. The components of these rubrics are each aligned to various outcomes found in the CCE meta-competency requirements (meta-competency outcomes) that are required to be assessed as part of the chiropractic education. Details of the 39 outcomes and how the tools align to the outcomes are available from the VPCO or the Dean of Clinical Education.

The CMR is used to measure the intern competence in case management including: clinical decision making, diagnosis, patient care, evidence informed care, etc. The ROF assessment is used to measure intern competence in reporting findings to the patient, communication skills, and informed consent. The PVE assessment is used to measure intern competence during a patient visit including: assessment, subluxation assessment, communication, adjustment skills, ancillary care skills, etc. All tools also include professionalism. Following each assessment, the data is analyzed and provided to the intern and the intern’s faculty mentor for use in providing formative feedback and determining readiness for practice.

Specific requirements for completing assessments and achieving competence are described earlier in this document.
Section 5

Health Center Manual
Health Center imaging department policies and procedures

The Administration of the College/Health Center reserves the right to add, deletes, or modify the Health Center’s policies and procedures as needed.
IMAGING POLICY
The use of ionizing radiation (x-ray) in health care has been one of the great advances of modern times. In the fullness of time, we have gained a greater appreciation for advantages and disadvantages of using this technology in patient evaluations. We have also gained a greater appreciation for the consequences of unnecessary or inappropriate use of this technology.

The policies and procedures herein have been designed to give the institution, our faculty and our interns a clearer sense of when and how to employ this technology. In diagnostic Imaging there is a tension between benefit and risk as well as between cost and efficiency. We hope that these policies and procedures will help orient you to the expectations we have of our interns, faculty and consultants (radiologists) with respect to the application of x-ray imaging in the College’s Health Center. These policies and procedures have been developed by the professional staff of the College’s Imaging Department, the College’s faculty teaching in the area of x-ray, the College’s Health Center faculty, the College’s chiropractic technique faculty and senior staff of the College’s Health Center.

General policies, procedures, clinical guidelines, and best practice strategies in radiology have been considered in relation to the unique needs of the Doctor of Chiropractic. An attempt has been made to reach a reasonable, rational and supportable position in the application of x-ray utilization guidelines and practices in the chiropractic environment appreciating the unique imaging needs and perspectives of the chiropractic community.

These policies and procedures apply to all situations where patients are exposed to ionizing radiation through the College’s Health Center. Questions regarding these procedures should be directed to the Director of Imaging of the Health Center. Further, these policies and procedures are applicable to all faculty and interns functioning in the College’s Health Center. Related administrators, faculty and interns are expected to be familiar with these policies and procedures, and to refer to them in the context of any and all decisions related to imaging questions in the Health Center. As you move through the information to follow, there will be detailed information about the expectations of interns, faculty, consultants and administrators.

All parties are expected to fulfill their responsibility in the decision-making, ordering, taking, reading, reporting and filing system sequence associated with the use of x-ray in the College’s Health Center. If anyone involved at any point throughout these processes has any suggestions or recommendations to facilitate the smoother and more efficient application of the policies and procedures herein, you are invited and encouraged to present your ideas to the Director of Imaging of the Health Center.
As an element of the Health Center’s Quality Assurance (QA) program, patient files are routinely reviewed. One area of this review process is related to the appropriate application of the policies and procedures detailed in this document as evidenced in patient files. Faculty members are expected to serve as a point of control relative to decisions related to the use of x-ray procedures. Consequently, the application of these policies and procedures by the Health Center faculty together with the professional judgment applied by the faculty are a key evaluation point during the QA process. As interns routinely receive feedback from Health Center faculty about patient interactions including imaging related decisions, so too do faculty receive feedback from the Health Center’s QA officer about their decisions related to these areas as well. Feedback from all parties involved in matters related to imaging in the College’s Health Center is routinely gathered, evaluated and acted upon as necessary.

In addition, new literature related to the use and interpretation of diagnostic imaging is continually coming forward. As a result, the Imaging Department reviews potential changes to these policies and procedures, and amends these materials when the need arises. When these materials are revised, there is an exchange with the Health Center Competency Testing Department, the x-ray related faculty and technique faculty to apprise every one of the changes and the timeframe for the implementation of the changes.

The decision to utilize ionizing radiation is based on the patient’s case history and examination findings. An intern is expected to propose any needed imaging studies to the Health Center faculty. All relevant patient information will be integrated with the professional judgment of the faculty in the context of these policies to determine which studies are to be ordered.

Imaging studies completed at the College’s Health Center must be completed following proper procedures for measurement of the patient, x-ray machine set-up, patient positioning, breathing instructions, shielding and all safety steps to insure minimal exposure to the patient, intern and Department personnel.

The entire x-ray process is the responsibility of the supervising x-ray faculty. The intern is expected to prepare for the x-ray appointment, be familiar with the studies to be conducted and be prepared to answer questions the patient or faculty member may have of them. A high level of sensitivity and professionalism is expected during the x-ray process.

A copy of the x-ray positioning protocols to be used in the Department and a copy of the California law and regulations law for radiology (Title 17) is available in the Imaging Department for intern reference. The following case presentation circumstances have been deemed to require an x-ray evaluation:

- Acute trauma with immediate loss of range of motion and pinpoint tenderness
- Patient with history of cancer
- Clinical suspicion of neoplasm or bone infection
- Evidence of cauda equina
Inability to bear weight on extremity
History of spinal and/or joint surgery in region to be adjusted

X-rays may be required in the following cases based on the clinical judgment of the faculty involved:
History of trauma in region to be adjusted
Midline spinal pain
Radicular symptoms with or without spinal pain
Suspicion of spinal instability with spinal pain during range of motion
Diabetes
Skin conditions ex: psoriasis, eczema
Neurological findings

X-rays may be required for biomechanical assessment based on the clinical judgment of the faculty involved:
Decreased range of motion, global
Decreased range of motion, segmental
Spinal or extremity tenderness upon palpation
Abnormal posture
Possibility of spinal anomaly, leg length inequality, suspicion of altered spinal curves

Additional x-rays may be requested by the faculty or the radiologist who has read the initial x-rays. The radiologist will notify the faculty member who will explain any required follow-up such as requesting previous x-rays, additional new x-rays, or referral recommended by the radiologist. Student x-rays are provided, when clinically necessary, at no cost to the student. Students are not permitted to be in the x-ray/imaging department outside of class time and imaging hours.

X-ray Appointment Sign up Procedure
The Life West Health Center Imaging Department is committed to high quality images and to efficient processes that provide images in a timely manner for patients, interns and faculty. Therefore, when a patient’s examination is complete and appropriate x-rays are approved by a faculty member, the intern may escort the patient to the imaging department for x-rays. Images will be taken on a first come, first serve basis. If imaging faculty are not available (i.e. Upper cervical specialists or imaging rooms are all being utilized), appointments can be made utilizing the MindBody system.


If you have a patient who is obese, please block out extra time as we may need to take additional
views or take some views recumbent. If patient measures greater than 45cm at the femur heads, patient may be referred to St. Rose Hospital for Images. If you have a patient with slow or altered ambulation please block out extra time and notify x-ray faculty when you sign up for the appointment.

All patients should be instructed to arrive 15 minutes prior to the x-ray appointment, a 10 minute grace period is allowed for late patients; otherwise the patient may be rescheduled for another time and/or day.

Imaging dept. procedures for intern not showing for scheduled x-ray,

First infraction: Warning
Imaging dept. will call/text the late intern informing them this is a warning
X-Ray Supervisors will alert the Director of Imaging of the Health Center, or the Health Center Operations Manager (in the director's absence) of the no show. They will then enter into remarks “No show in x-ray warning given” in remarks on the Intern’s Chiro Clinic Page

Second infraction; withdraw of 5 adjustment credits.
X-Ray Supervisors will alert Director of Imaging of the Health Center, or the Health Center Operations Manager (in the director’s absence) of the no show. Then they will enter “No show second infraction, 5 adjustment credits taken.” into remarks
Notice of concern will be filled out by Director of Imaging of the Health Center, and given to the Vice President of Clinical Operations

Patient arrival and pre-radiographic preparation procedure

The patient must sign in at the front desk and receive a visit slip.
The intern should be ready with a gown, and will escort the patient to the Imaging Department front desk. The intern will check in with the Imaging Department faculty. The intern must have the imaging request form filled out and the appropriate x-rays initialed by a Faculty Mentor, and removed from file. The intern gives the “Imaging Request” form and the “Visit Slip” to the Imaging Faculty. The faculty will direct the intern to the appropriate room.
If the patient is female, once in the x-ray room (for privacy, not in the waiting room, hallway, etc) the patient must sign the pregnancy waiver in the file on the Imaging Request page.
The intern will instruct the patient regarding proper gowns procedures. Please take the time to give clear, specific instructions. The patient may leave on underwear but should remove bra.

Instruct patient to put the gown on with the opening in the back, and to ask for assistance to close the gown if needed. The patient is instructed to remove all jewelry/metal/dentures/hair-pins/bras/ etc. that are in the area of the x-ray views. Rings and watches may be left on unless an upper extremity view is being taken. The patient should remove their shoes; there are paper
slippers available in the dressing room if they choose. The only people allowed in the x-ray room are the faculty, work study student if available, the intern and patient. When a minor child is being x-rayed, the parent or guardian is allowed in the room. The consent to x-ray a minor form must be signed, and the parent or guardian must be present during the procedures.

Once the patient is gowned, the intern will perform the required measurements of the patient and record the results on scratch paper, and give to the doctor.

**Post x-ray procedure**
After the x-rays are taken, and the x-ray faculty has approved them, the intern will instruct the patient to dress.
The intern will make certain they give a copy of the imaging request to the Imaging Department Faculty.
The intern will fill out the faculty evaluation, and have their patient fill out the imaging department evaluation, and turn in to the Director of Quality Assurance.
The intern will escort their patient to the cashier with the visit slip signed by the x-ray faculty.
The x-ray faculty will fill out the intern Imaging Assessment form, noting their progress in x-ray positioning. (See form below.)

**Outside Images to be uploaded to Opal** (Sample – on Canvas)
If an outpatient brings existing images that are less than 5 years old, the intern will fill out the imaging requisition form and attach a copy of such form to accompany the images. Give a copy to the Imaging Department Faculty who will scan and upload them into Opal. (MRI's are not loaded into Opal, but if there is no radiology report, they can be made into a report.) After images are scanned or read, they will be returned to the Records Room.

**Overcoming patient anxiety regarding x-ray**
Keep in mind that patients often experience anxiety about having x-rays and the exposure to radiation.
You must help to alleviate these concerns from the very beginning of the patient care process. Some patients have had a great deal of radiation history, and others have had little. The best way to offset this is to clearly explain what will be done, and how the x-ray examination will be conducted.
Every question the patient asks must be answered; if you are at all unsure of the correct answer the intern must have his/her mentor or x-ray faculty speak to the patient.

**X-ray record requests** (Sample – on Canvas)
X-rays are the property of Life Chiropractic College West and are not to be taken from the Health Center. The Health Center will, however, provide a copy of the patient’s x ray to a third-party following receipt of a signed authorization from the patient. There is a charge for each x-ray copy requested. When it is necessary to provide the original x-ray, it will be
mailed on loan to the party indicated by the patient. All images are expected to be returned within a thirty-day period.

**Required Lines of Mensuration:**
After images have been obtained, the intern is responsible for the performance of the following biomechanical interpretations before the patient file may be submitted for a PDCS approval.

**Atlantodental Interspace (ADI)**
Film: Lateral Cervical
This is the distance between posterior margin of the anterior arch of atlas and the anterior surface of the odontoid process as measured on the neutral lateral cervical film at 72 inches FFD. The size of the space assists in determining C1-2 stability. ADI is also considered abnormal if it increases during cervical flexion. Increased ADI may be caused by changes in the transverse ligament, such as in rheumatoid arthritis or traumatic injury. Normal:
- Adult 1-3 mm
- Child 1-5 mm

**Physiological lines of stress (Ruth Jackson’s lines)**
Film: Lateral Cervical (Flexion, Extension)
Procedure: Draw a line along the posterior margin of the body of Axis. Draw a line along the posterior margin of the body of C7. Extend both lines until they meet. Normal: The lines should intersect between C4-5 on the extension lateral and between C5-6 on the flexion lateral.

Significance: Marked alterations in the point of greatest stress and strain indicate limitations of motion due to advancing degenerative changes and discogenic spondylosis. Care must also be taken to consider the overall architecture of the spine before placing too much significance on this line.
The normal cervical architecture will cause an abnormal finding which will be normal for that individual. Congenital hyperlordosis is the best example of this.

**Gravitational line from the Odontoid Process**
Film: Lateral Cervical.

Procedure: A vertical line is drawn from the apex of the odontoid inferior to the level of C7. Normal: The line should fall within the antero-superior 1/3 of the body of C7.
Significance: Anterior to the normal range may indicate hypolordosis while Posterior to the normal range may indicate hyperlordosis of the cervical spine.

**George’s Line**
Film: Lateral Cervical.
Procedure: The line is created by drawing a continuous line on the posterior vertebral body surfaces.
Care should be taken to not draw the lines connecting the superior and inferior body angles due to the frequency of hypertrophic changes in this area which must not be obscured from view by the pencil line. Normal: The series of short lines should form a smooth, continuous anterior arc. Significance: The line is useful in determining flexion or extension subluxations of the vertebra as these subluxations will alter the smooth flowing line to some degree, depending upon severity. Rotation will tend to give a false positive if care is not exercised in positioning this line. Anterolisthesis and retrolisthesis will also alter this line. Differentiation should be made between a “break” and an “interruption” in George’s Line. A “break” refers to a distinct anterior or posterior slippage effectively breaking the continuity of the line while an “interruption” is an alteration of the smooth continuity of the arc caused by flexion or extension subluxations.

**Cobb’s Method for determining scoliosis**
On the standard antero-posterior film, determine the end vertebra of the curvature, the highest vertebra with its superior border inclined toward the concavity and the lowest vertebra with its inferior border inclined toward the concavity. Extend these on the concave side and draw intersecting perpendiculars. The resultant angle is measured. Generally, a 5-degree increment over the Risser-Ferguson method will be obtained by this method. The Cobb’s Method is this Health Center’s preferred method. Angles greater than or equal to 20 degrees is considered scoliosis.

**Risser-Ferguson Method for determining scoliosis**
On the standard antero-posterior projection, the vertebrae situated at the extreme ends of the curvature, (the highest vertebra at the end of the curve which is the least rotated and lies between the two curves and the lowest vertebra in the curve demonstrating the same positional characteristics), are marked with a dot in the center of the bodies. In the curvature, a similar dot is placed on the apical vertebra at the peak of the curve. Lines are drawn connecting the distal dots and intersecting at the apical point. These are then joined, and their intersecting acute angle measured. When using either the Cobb or Risser-Ferguson Method, the same end vertebrae must be used when measuring comparison films.

**Ferguson’s Gravitational Line**
Film: Lateral Lumbar.
Procedure: Draw a line from the center of the body of L3 at 90 degrees to the bottom of the film. Normal: The line should cross the anterior third of the sacral base
Significance: When the line falls >1 mm anterior to normal it may indicate an increase in anterior shearing stress on the L5-S1 facet joints. Posterior shift in the gravity line may be a sign of
increased weight bearing on the lumbo-sacral facets. The line is of little significance when a transitional lumbo-sacral segment is present.

**Ferguson’s Sacral Base Angle**
Film: Lateral Lumbar.

Procedure: Draw a true horizontal line from the edge of the film. Draw a line along the sacral base intersecting with the horizontal line. Measure the acute angle formed by the intersection.
Normal: 26-57 degrees.
Significance: An increased sacral base angle may exacerbate shearing and compressive forces on the posterior lumbo-sacral joints.
Much variation in this angle has been found by the various researchers’ studying it. One consistency arises in that almost all attribute an approximate 8-12 degree increase in the standing angle over the supine. The angle is of great significance in analyzing the lumbo-sacral motor unit’s stability and strength.

**Lumbo-Sacral Disc Angle**
Film: Lateral Lumbar.
Procedure: Draw a line along the sacral base. Draw a line along the bottom of the body of L5. Extend both lines until they intersect. The resulting angle is measured.
Normal: The angle should measure 10-15 degrees.
Significance: Angle > 15 degrees indicates facet impaction which may cause low back pain Angle < 10 degrees may result from acute disc herniation at L5
Please note that while Ullman’s Line is included in the sketches below, it is NO LONGER a required line of mensuration in the Health Center.
Section 6
Health Center Manual
Patient Responsibilities, Customer Services and Fee Schedules

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
PATIENT BILL OF RIGHTS
The Monte H. Greenawalt Health Center guarantees all patients have the right:

- Receive chiropractic health care without regard to race, color, religion, sex, national origin disability, sexual orientation, or source of payment.
- Full consideration of privacy concerning care. Case discussion, consultation, examinations, and care shall be treated confidentially and conducted discreetly. Patients have the right to be advised as to the reason for presence of any individual during care.
- Confidential treatment of all communications and records pertaining care. Know the identity and professional status of individuals providing care.
- Receive information from the individual(s) responsible for coordinating care; concerning diagnosis\analysis, prognosis and the planned course of care in understandable terms.
- Receive as much information about any proposed care or procedure as is needed in order to give informed consent or to refuse the course of care.
- Refuse to participate in any research project. Participation in a clinical training program or the gathering of data for research purpose is always voluntary.
- Description of chiropractic care, or procedures, the significant risks involved and alternate course of care.
- Participate actively in decisions regarding chiropractic health care.
- Expect reasonable safety insofar as health care environment is concerned.
- Consultation with another health care practitioner at his or her own request and expense.
- Receive an itemized detailed and through explanation of the total charges billed for services rendered, regardless of source of payment.
- Access the information in their own patient file.
- Present complaints, receive information on how to do so, and be provide with a response when making a significant complaint. Presentation of a complaint does not in itself to serve to compromise a patient’s future access to care.

Patient Responsibilities
Each Health Center patient is an active participant in their care and must ensure that his\her actions do not infringe upon the rights of other patients or the rights and responsibilities of the Health Center. Patients shall be responsibilities for:

- Providing to the best of his\her ability and knowledge: accurate and complete information about present complaints, past illness, incidents, Hospitalizations, and medications. It is the patient’s responsibility to report any new episode of trauma or any unexpected changes in her\his health condition to the health care practitioner.
- Following the recommended care plan.
- Keeping appointments and notifying appropriate practitioner when unable to do so.
- The consequences if she\he refuses care or does not follow up with the practitioner’s
instructions.
- Assuring that the financial obligations for health care are fulfilled as promptly as possible.
- Following the Health Center rules and regulations affecting patient care and conduct.

**Patient Care Fee Schedule**

Standard Fees Service

- Initial Examination: $65.00
- Office Visit: $30.00
- Office Visit/No Adjustment: $30.00
- Re-Evaluation Exam: $30.00
- Re-Evaluation with Adjustment: $45.00
- Ancillary Procedures: $10.00
- Transfer Exam: $0.00
- Re-activation: $65.00

(One year or more since last visit)

X-Rays (if necessary): $40.00 – $120.00 per series

Any questions or concerns should be directed to the Health Center Operations Manager.

**Laboratory:**

(Lab Corp provides all service billing and collection – See Health center Front Desk for complete price listing) Draw fee required for all blood work.

**Rehab and Fitness**

The following patient care products are available for patient purchase in the Health Center. The item must be approved in the management plan and the visit slip signed by the faculty. The signed visit slip is taken by the intern to the Records Room where the staff member will dispense the product. The patient will pay for the item at the Cashier’s station. The fees are available on the Online Store in Mindbody. Prices may be subject to change.

**X-Rays: See x-ray Fee Schedule:**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Spine -3V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Cervical Spine -5V</td>
<td>$60.00</td>
</tr>
<tr>
<td>Cervical Spine -7-V</td>
<td>$90.00</td>
</tr>
<tr>
<td>Thoracic Spine -2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Thoracic Spine\Swimmer’s -3V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Thoracolumbar Spine -2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Lumbar Spine</td>
<td>$40.00</td>
</tr>
<tr>
<td>Lumbar Spine Complete-4or 5</td>
<td>$60.00</td>
</tr>
<tr>
<td>Pelvis AP</td>
<td>$20.00</td>
</tr>
<tr>
<td>Sacroiliac Joints-1 V</td>
<td>$20.00</td>
</tr>
<tr>
<td>Sacrum\Coccyx-2</td>
<td>$40.00</td>
</tr>
<tr>
<td>Cheat PA-1V</td>
<td>$20.00</td>
</tr>
<tr>
<td>Cheat -2 V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Ribs, Unilateral</td>
<td>$40.00</td>
</tr>
<tr>
<td>Ribs, Bilateral</td>
<td>$60.00</td>
</tr>
<tr>
<td>Abdomen KUB -2V</td>
<td>$30.00</td>
</tr>
<tr>
<td>Full Spine -2V</td>
<td>$120.00</td>
</tr>
<tr>
<td>Basic 4 Scoliosis</td>
<td>$120.00</td>
</tr>
<tr>
<td>Basic 7</td>
<td>$120.00</td>
</tr>
<tr>
<td>Pre NUCCA</td>
<td>$60.00</td>
</tr>
<tr>
<td>Hip Complete -3 V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Hip Bilateral 4V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Femur-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Knee-2V</td>
<td>$60.00</td>
</tr>
<tr>
<td>Knee Complete</td>
<td>$60.00</td>
</tr>
<tr>
<td>Tibia\Fibula</td>
<td>$40.00</td>
</tr>
<tr>
<td>Ankle-2V</td>
<td>$30.00</td>
</tr>
<tr>
<td>Procedure</td>
<td>Price</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Ankle Complete</td>
<td>$40.00</td>
</tr>
<tr>
<td>Foot-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Foot Complete -3V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Calcaneus-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Toes -2 Minimum</td>
<td>$40.00</td>
</tr>
<tr>
<td>Shoulder 2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Shoulder Child -3</td>
<td>$40.00</td>
</tr>
<tr>
<td>Clavicle Complete</td>
<td>$40.00</td>
</tr>
<tr>
<td>Humerus-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Scapulae Complete</td>
<td>$40.00</td>
</tr>
<tr>
<td>Elbow -2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Elbow Complete -3 or 4V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Radius\Ulna-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Wrist -2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Wrist Complete</td>
<td>$40.00</td>
</tr>
<tr>
<td>Hand-2V</td>
<td>$40.00</td>
</tr>
<tr>
<td>Hand Complete-3</td>
<td>$40.00</td>
</tr>
<tr>
<td>Fingers-2V Minimum</td>
<td>$40.00</td>
</tr>
<tr>
<td>Single Film Any Area</td>
<td>$20.00</td>
</tr>
<tr>
<td>Radiology Report</td>
<td>$30.00</td>
</tr>
<tr>
<td>Bone Density Scan</td>
<td>$25.00</td>
</tr>
<tr>
<td>Balance Assessment</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

### Post Films

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post NUCCA</td>
<td>No charge</td>
</tr>
<tr>
<td>Post Advo</td>
<td>No charge</td>
</tr>
<tr>
<td>Post CBP</td>
<td>No charge</td>
</tr>
<tr>
<td>Post Heel Lifts</td>
<td>No charge</td>
</tr>
</tbody>
</table>
# PRODUCTS FOR SALE IN THE HEALTH CENTER

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Color</th>
<th>Size</th>
<th>Our Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denneroll - Cervical</td>
<td>Cervical</td>
<td>Large</td>
<td>$29.95</td>
</tr>
<tr>
<td>Denneroll - Cervical</td>
<td>Cervical</td>
<td>Medium</td>
<td>$29.95</td>
</tr>
<tr>
<td>Denneroll - Cervical</td>
<td>Cervical</td>
<td>Small</td>
<td>$29.95</td>
</tr>
<tr>
<td>Denneroll - Lumbar</td>
<td>Lumbar</td>
<td>Large</td>
<td>$39.95</td>
</tr>
<tr>
<td>Denneroll - Lumbar</td>
<td>Lumbar</td>
<td>Medium</td>
<td>$39.95</td>
</tr>
<tr>
<td>Denneroll - Lumbar</td>
<td>Lumbar</td>
<td>Small</td>
<td>$39.95</td>
</tr>
<tr>
<td>Denneroll - Thoracic</td>
<td>None</td>
<td>None</td>
<td>$29.95</td>
</tr>
<tr>
<td>Pro-Lordotic Neck Exerciser</td>
<td>Blue</td>
<td>Medium Pull</td>
<td>$35.00</td>
</tr>
<tr>
<td>Pro-Lordotic Neck Exerciser</td>
<td>Green</td>
<td>Hard Pull</td>
<td>$35.00</td>
</tr>
<tr>
<td>Pro-Lordotic Neck Exerciser</td>
<td>Red</td>
<td>Easy Pull</td>
<td>$35.00</td>
</tr>
<tr>
<td>Foot Levelers</td>
<td>None</td>
<td>None</td>
<td>$125.00</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>None</td>
<td>Large</td>
<td>$8.85</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>None</td>
<td>Medium</td>
<td>$8.85</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>None</td>
<td>Small</td>
<td>$8.85</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>None</td>
<td>X Large</td>
<td>$8.85</td>
</tr>
<tr>
<td>Bodysport Balance Disc</td>
<td>None</td>
<td>None</td>
<td>$22.99</td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>None</td>
<td>2”</td>
<td>$8.74</td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>None</td>
<td>3”</td>
<td>$6.60</td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>None</td>
<td>4”</td>
<td>$6.60</td>
</tr>
<tr>
<td>Double Strap Ankle Support</td>
<td>None</td>
<td>Medium</td>
<td>$12.95</td>
</tr>
<tr>
<td>Double Strap Ankle Support</td>
<td>None</td>
<td>Small</td>
<td>$12.95</td>
</tr>
<tr>
<td>Double Strap Ankle Support</td>
<td>None</td>
<td>X Large</td>
<td>$12.95</td>
</tr>
<tr>
<td>Elastic Criss Cross Support w/Double Pull</td>
<td>None</td>
<td>Large</td>
<td>$25.50</td>
</tr>
<tr>
<td>Elastic Criss Cross Support w/Double Pull</td>
<td>None</td>
<td>Medium</td>
<td>$25.50</td>
</tr>
<tr>
<td>Elastic Criss Cross Support w/Double Pull</td>
<td>None</td>
<td>Small</td>
<td>$25.50</td>
</tr>
<tr>
<td>Elastic Criss Cross Support w/Double Pull</td>
<td>None</td>
<td>X Large</td>
<td>$25.50</td>
</tr>
<tr>
<td>Elastic Wrist with Metal Stay</td>
<td>Left</td>
<td>Large</td>
<td>$10.45</td>
</tr>
<tr>
<td>Elastic Wrist with Metal Stay</td>
<td>Left</td>
<td>Medium</td>
<td>$10.45</td>
</tr>
<tr>
<td>Elastic Wrist with Metal Stay</td>
<td>Right</td>
<td>Large</td>
<td>$10.45</td>
</tr>
<tr>
<td>Elastic Wrist with Metal Stay</td>
<td>Right</td>
<td>Medium</td>
<td>$10.45</td>
</tr>
<tr>
<td>Figure 8 Ankle Wrap</td>
<td>None</td>
<td>Large</td>
<td>$5.30</td>
</tr>
<tr>
<td>Figure 8 Ankle Wrap</td>
<td>None</td>
<td>Medium</td>
<td>$5.30</td>
</tr>
<tr>
<td>Figure 8 Ankle Wrap</td>
<td>None</td>
<td>X Large</td>
<td>$5.30</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Kids Special Order</td>
<td>3mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Kids Special Order</td>
<td>5mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Kids Special Order</td>
<td>7mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Kids Special Order</td>
<td>9mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Large 3mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Large 5mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Large 7mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Large 9mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Small 3mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Small 5mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Ladies</td>
<td>Small 7mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Large 3mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Large 5mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Large 7mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Large 9mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Small 3mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Small 5mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Small 7mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Heel-Lifts-Cork</td>
<td>Mens</td>
<td>Small 9mm</td>
<td>$2.45</td>
</tr>
<tr>
<td>Item</td>
<td>Size</td>
<td>Price</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies 3mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies 5mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies 7mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies 9mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies small 12mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies small 3mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies small 5mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies small 7mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Ladies small 9mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Mens 3mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Mens 5mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Mens 7mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Heel Lifts Rubber Mens 9mm</td>
<td></td>
<td>$2.05</td>
<td></td>
</tr>
<tr>
<td>Lift Patellar Tendon Sleeve None</td>
<td>Large</td>
<td>$15.95</td>
<td></td>
</tr>
<tr>
<td>Lift Patellar Tendon Sleeve None</td>
<td>Medium</td>
<td>$15.95</td>
<td></td>
</tr>
<tr>
<td>Lift Patellar Tendon Sleeve None</td>
<td>Small</td>
<td>$15.95</td>
<td></td>
</tr>
<tr>
<td>Lift Patellar Tendon Sleeve None</td>
<td>X Large</td>
<td>$15.95</td>
<td></td>
</tr>
<tr>
<td>Lumbar Belt None</td>
<td>Large</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>Nylon and Neoprene Wrist Wrap None</td>
<td>One Size</td>
<td>$8.45</td>
<td></td>
</tr>
<tr>
<td>PALS Reusable Electrodes, Platinum</td>
<td>Z&quot;</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Female None</td>
<td>Large</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Female None</td>
<td>Medium</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Female None</td>
<td>Small</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Female None</td>
<td>X Large</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Female None</td>
<td>XX Large</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Male None</td>
<td>Medium</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Male None</td>
<td>Small</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Male None</td>
<td>X Large</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Rib Belt Male None</td>
<td>XX Large</td>
<td>$10.55</td>
<td></td>
</tr>
<tr>
<td>Sacro Wedge Plus None</td>
<td>One Size</td>
<td>$45.00</td>
<td></td>
</tr>
<tr>
<td>Sure-Fit Tennis Elbow Support None</td>
<td>One Size</td>
<td>$7.00</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Exercise Handles None</td>
<td>One Size</td>
<td>$8.25</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Flat Band (per foot)</td>
<td>Black</td>
<td>$0.85</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Tubing (per foot)</td>
<td>Black</td>
<td>$0.70</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Tubing (per foot)</td>
<td>Blue</td>
<td>$0.65</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Tubing (per foot)</td>
<td>Red</td>
<td>$0.55</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Tubing (per foot)</td>
<td>Silver</td>
<td>$0.80</td>
<td></td>
</tr>
<tr>
<td>Thera-Band Tubing (per foot)</td>
<td>Yellow</td>
<td>$0.50</td>
<td></td>
</tr>
<tr>
<td>TheraFlex Hot/Cold Therapy Packs</td>
<td>12x15</td>
<td>$6.00</td>
<td></td>
</tr>
<tr>
<td>TheraFlex Hot/Cold Therapy Packs</td>
<td>5x10</td>
<td>$2.00</td>
<td></td>
</tr>
<tr>
<td>TheraFlex Hot/Cold Therapy Packs</td>
<td>8x11</td>
<td>$4.50</td>
<td></td>
</tr>
<tr>
<td>Trochanter Belt Double Pull None</td>
<td>26'-38&quot;</td>
<td>$11.25</td>
<td></td>
</tr>
<tr>
<td>Trochanter Belt Double Pull None</td>
<td>38'-48&quot;</td>
<td>$11.25</td>
<td></td>
</tr>
<tr>
<td>Adrenal Health Packs None</td>
<td>60 PKS</td>
<td>$59.00</td>
<td></td>
</tr>
<tr>
<td>Bone Health None</td>
<td>60 PKS</td>
<td>$102.00</td>
<td></td>
</tr>
<tr>
<td>General Female Endocrine Daily Fundamentals None</td>
<td>60 PKS</td>
<td>$88.00</td>
<td></td>
</tr>
<tr>
<td>General Health Packs None</td>
<td>60 PKS</td>
<td>$61.00</td>
<td></td>
</tr>
</tbody>
</table>
Health Center Protocol for Addressing Patient Inquiries and Concerns:

It is Health center policy to provide the highest level of patient care in an atmosphere of respect, courtesy and service. Our goal is for all patients to be completely satisfied with the services provided, and to invite an open dialog that contributes to the realization of that endeavor. We also realize that there will be times when patients may desire to discuss their care, or other matters that relate to their experiences at the Health Center. This protocol describes the sequence of response the Health Center has implemented to ensure that our patient requests, concerns, or other Issues are handled promptly, efficiently, and thoroughly.

Customer Service Inquiries or Concerns:
Issues that do not involve patient care but are related to activities of customer service, operations, the facility billing or similar topics are to be directed to the Health Center Operations Manager.

Patient Care Inquiries or Concerns:
Issues involving patient care, as intern's provision of services, supervising faculty functions or similar topics, are to be directed to the Compliance Officer.

Unresolved Inquiries or Concerns:
Any inquiries or concerns presented by a patient that is not promptly resolved through the above – described systems, should be immediately presented to the EVP of the Health Center for review and response. If the EVP is unavailable the time, please provide a contact information for the patient(s) and any necessary details to facilitate a timely response upon the administrator’s return or first availability.

Patient Categories – Cash Patient
The patient care fee schedule*(see preceding pages) applies to cash patients. See Customer Service Assistants for complete fee schedule.

Minor Cash Patient
A minor is any patient who is 17 years of age or younger. The Health Center charges the following for minor patients:
Initial examination and x-rays, interim examinations, laboratory and ancillary services are provided at the standard patient care fee schedule.
Adjustments are provided at a discounted rate for minors if the parent is an active patient; otherwise, the fees are at the standard patient care fee.

Spouse Fee Schedule:
A discounted fee schedule only applies to patients whose spouse with an A file is currently an active patient. See the customer service manager for the fee schedule.
<table>
<thead>
<tr>
<th>Service</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Examination</td>
<td>$65.00</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$22.00</td>
</tr>
<tr>
<td>Re-evaluation + Adjustment</td>
<td>$37.00</td>
</tr>
<tr>
<td>Reactivation</td>
<td>$65.00</td>
</tr>
<tr>
<td>Physical Therapy/Modalities</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

**X-RAY**

<table>
<thead>
<tr>
<th>Service</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic 7</td>
<td>$120.00</td>
</tr>
<tr>
<td>Scoliosis Basic 4</td>
<td>$120.00</td>
</tr>
<tr>
<td>AP / LAT Full Spine</td>
<td>$120.00</td>
</tr>
<tr>
<td>Pre-NUCCA</td>
<td>$60.00</td>
</tr>
<tr>
<td>Post-NUCCA</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

*Laboratory Fees: Lab Corp Laboratories provides all lab services, including billing and collections. See Receptionist for additional information on services and fees*

**Insurance Patient**

*The Health Center accepts Medicare Part B insurance.* The Billing Specialist will fill out the necessary forms for reimbursement. The patient is responsible for any amounts not paid Medicare including deductibles, co-payment(s), and non-covered service(s). Patients must pay for services rendered on the same day. Medicare patients will be reimbursed when payment is received from company.

Patients who have questions about insurance should be directed to the Billing Specialist. If a patient wants, he or she may bill their own insurance company for services. The Billing Specialist will provide a visit summary statement to the patient for this purpose.

**Medicare Patients**

Any patient who has Medicare Part B Coverage. The patients submit a copy of their Medicare card for proper identification.

The patient is required to pay the standard fee all examinations, x-rays and ancillary services that are considered non-coverage services by the Medicare program.

Consideration for Office Visits only (adjustment) only.

The patient is required to pay the annual Medicare deductible amount or co-payment, when applicable.

The primary diagnosis, on the patient’s file and Medicare claim must indicate that of “Spinal Subluxation”. Medicare accepts NO Other diagnosis codes in consideration of reimbursement. According to the Medicare program, “there no certain number of treatments that will be covered automatically”. The need for a service must be based upon the acute treatment
modifier requirement. Effective Oct. 1\textsuperscript{st} 2004 Medicare is requiring all physicians to code each visit with or without a modifier, depending on whether or not the care provided on that visit was maintenance care. Medicare has designed the modifier AT (Acute Treatment) for expected to case improvement in or arrest the progression of the patient’s condition. The AT modifier can also be used with chronic patients when the adjustment can be expected to result in functional improvement.

Medicare patients may seek other facilities, which will accept Medicare for x-ray reimbursement. The LCCW Health Center will accept the transfer of those x-rays. All medicare patients’ chief complaints for that day will be adjusted by the practice advisor.

**Ancillary Services**

Any service or product provided by Health Center other than Examinations, x-rays, adjustments or physiotherapy. Example: report of findings cervical collar, ice pack, supports.

**Payment Policy**

Our standard fee schedule has been created to help defray the costs of health care. We have minimized our billing procedures to eliminate expense that would otherwise necessitate higher fees.

Payment is due on the day service(s) and/or product(s) are provided. The Health Center accepts payments by cash, check (with proper identification), all major credit cards.

**Health Center Fees for Students, Faculty\Staff & Faculty\Staff Family Patients**

All physical examinations, adjustments, and physiotherapy are provided at no charge. Students receive a one-time x-ray credit for a student Radiographic Package (Imaging Supplemental, page3). This package consists of cervical, thoracic, and/or lumbar/pelvic series and base posterior view.

Students Family and student courtesy x-rays are provided at no charge as above. Faculty\staff and family x-rays are provide at no charge.

All patients must pay for lab work at the lab facility. Release of Patient Records

Copies of health records are only released with a valid release of records request. The cost for copies is as follow:

Copies if health records or of x-rays are provided at no cost for patients who are referred by us to another facility.

There is a $15.00 fee for health records requested by either a patient or another facility. There is a $10.00 fee for x-rays requested by either a patient or another facility.
Records will process each request once release of records request form has been filled out and payment.

Charges for copies of records are supported by the Health and Safety Code 123110 (B) (C).