# Logan

College of Chiropractic

## Health Center Handbook

LOGAN COLLEGE OF CHIROPRACTIC/UNIVERSITY PROGRAMS

LOGAN COLLEGE OF CHIROPRACTIC/ UNIVERSITY PROGRAMS HEALTH CENTERS

# Health Center Handbook


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# The Health Center Experience

## Welcome

Congratulations on your progression into the Logan Health Center System! You have reached the stage where application of knowledge and skills is integrated into patient care. You are transitioning from the being a 'student' to the esteemed position of a doctor. We welcome you in the final phase of your development with the commitment to fully prepare you as a professional, successful and clinically competent Doctor of Chiropractic.

The faculty, staff, and senior intern assistants are ready to assist you with all facets of your clinical experience. Interns are encouraged to ask questions and to develop a business-like, professional working relationship with their assigned Clinician as well as all clinical faculty.

The experience that you receive in the Health Centers is the culmination of many intense hours spent in study. The responsibilities you have assumed as an Intern are very serious. In essence, you are accepting responsibility for the health and well being of every patient with whom you come into contact. In the chiropractic profession, we influence the bodies and minds of those patients who place their trust in us to provide quality health care.

The Health Center faculty/Clinicians are responsible for guiding your transition from student to graduate doctor. The transition is multi-faceted—not only does the Health Center experience mold an image of a doctor through attitude and appearance, but it's also a catalyst in the development of a conscientious doctor who is mentally and technically trained in the art, science, and practice of Chiropractic.

We have confidence in you. You have demonstrated your clinical proficiency repeatedly. As Interns, you have rules, regulations, and policies to guide your health center experience. We trust it is your good intention to work with us for the health and safety of our Health Center patients. For any intern in whom our trust is misplaced, there are a variety of sanctions possible that include, but are not limited to, probation, suspension, or dismissal.

We depend on you to uphold your assigned responsibilities, though many of them may seem tedious or repetitive. These tasks are designed to streamline the educational process and coordinate the activities of several hundred Interns.

We extend an invitation to you to work harder than you have ever worked, for the noblest goal which you have ever achieved: your transformation into a skilled, successful, and competent Doctor of Chiropractic.

## Logan University Vision

Logan University will be recognized nationally as a community of learners inspired to lead a life of significance.

## Logan University Mission

Logan University is a diverse and engaging community committed to excellence in health sciences, education, and service, guided by integrity, commitment, and passion.

## Logan College of Chiropractic Vision

Logan College of Chiropractic is a premier graduate educational institution and the College of choice for those men and women dedicated to providing exceptional patient care that promotes wellness and individual quality of life.

## Logan College of Chiropractic Mission

Logan College of Chiropractic prepares students to become Doctors of Chiropractic who are superbly educated and clinically competent practicing portal of entry chiropractic physicians. This mission is accomplished through our dedicated faculty recognized for student centered excellence; comprehensive science-driven, knowledge-based, and information facilitated curriculum; enhanced by community and public service. The institution is committed to the conduct of research and other scholarly activities.

## The Chiropractor's Oath

In accordance with the Laws of Nature, and in consequence of my dedication to getting the sick well by the application of that law, I promise and swear to keep, to the best of my ability and judgment, the following Oath:

I will observe and practice every acknowledged rule of professional conduct in relation with my profession, my patient, my colleagues and myself.

I will keep an open mind regarding the progress of my profession, provided that these progressions shall be confined within the boundaries of the Chiropractic Science, Philosophy and Art.

I will serve my patients to the best of my ability, violating neither their confidence nor their dignity, and in my association with patients I shall not violate that which is moral and right.

I will regard and refer to my fellow chiropractors with honor, giving credit where it is due.

I shall improve my knowledge and skill, firm in my resolution to justify the responsibility which the degree of Doctor of Chiropractic symbolizes and imposes.

To all this, I pledge myself, knowing these ideals are prescribed by the dictates of reason alone.

## The Chiropractor's Creed

I solemnly pledge to use the science and art of chiropractic to promote the health and well being of all humanity.

I resolve that the healing skills which have been taught to me will ever be used in the name of service, and never for self-gain.

I shall strive to bring credit to my teachers, my profession, and my community.

I shall actively continue to learn and to improve my skills throughout my lifetime, and will be receptive to constructive change in my profession.

I shall always place the health and welfare of my patient above all other considerations.

I shall not represent myself or my profession to others and will never use my knowledge of chiropractic to cause harm or injury to any person.

I shall render care to my patient to the best of my ability without regard to religion, race, gender, nationality, social standing or political belief.

I shall not denigrate those in my profession who choose to use methods different from my own.

I shall regard and refer to my colleagues in the chiropractic and in other health care professions with respect.

I shall hold in confidence all information on my patient which I have not been given permission to release.

I make this pledge of my own free will and will follow its tenets in good health.

## Logan University Objectives

Board of Trustees Board Policy #002:

The following is the Purpose and Objectives Statement for Logan University:

A Doctor of Chiropractic, as a member of the healing arts, is a physician concerned with the health needs of the public. Particular attention is given to the relationship of the structural and neurological aspects of the body in health and disease. Chiropractic education stresses basic and clinical sciences as well as related health subjects.

The purpose of the professional education is to prepare the Doctor of Chiropractic as a primary health care provider. As a portal of entry to the health delivery system, the chiropractic physician must be well trained to diagnose, including, but not limited to, spinal analysis, to care for the human body in health and disease and to consult with, or refer to, other health care providers.

Logan University endeavors to provide an educational environment which promotes both excellence in the practice of chiropractic in its present state, and further progress in the art of chiropractic as a separate and distinct healing approach. Logan University emphasizes preventive management and maintenance of good health. The Institution recognizes that the body has a self-healing ability for the restoration of health. It is recognized in chiropractic that no part of the body is an isolated entity; therefore, the whole body must be treated from a holistic approach in which structural integrity and nutrition are emphasized.

Logan University prepares students to become doctors of chiropractic who are exceptionally educated and clinically competent practicing portal of entry chiropractic physicians. This is accomplished through dedicated faculty recognized for student-centered excellence; comprehensive science-driven, knowledge-based and information facilitated chiropractic curriculum; enhanced by community and public service. The institution is involved in the study and research that defines human structural dysfunction and neuro-musculoskeletal abnormalities of the physical and organic being.

The objectives of Logan University are specifically:

1. To provide the highest possible quality education, leading to a Doctor of Chiropractic degree, the recipient of which will be a primary health care provider serving as a portal of entry to the health care delivery system.
2. To emphasize through its educational program a thorough understanding of body mechanics, competence in differential diagnosis and an extensive clinical experience including patient management, treatment and the utilization of adjunctive therapeutics.
3. To provide a thorough basic science foundation, leading to a degree of Bachelor of Science, which stresses neural integration, nutritional principles and therapy, anatomy, physiology and pathology.
4. To develop in each individual student a sound philosophy of Chiropractic practice, independence of judgment, discriminating personal habits and a desire to work in the best interests of his patients and his profession.
5. To develop, organize and continue fundamental and clinical research programs in the field of chiropractic for the benefit of the public and to augment undergraduate and graduate programs.
6. To offer chiropractic physicians the opportunity to keep current with new findings through a graduate school program of continuing education.
7. To respond to the needs of the community in the area of health programs and to cooperate with the health officials of city, county, and state, in carrying out programs without discrimination or bias of race, color, religion, national origin, gender, age, disability, veteran status, or social or economic status.

## Scope of Practice

The Clinician's scope of practice in any Logan Health Center is determined by the laws of the State of Missouri which have been implemented by the Health Center Administration and Logan University's College of Chiropractic:

- The Intern is permitted to practice only under the direct supervision of a Health Center Clinician. Because of state statute, consulting, advising, history taking, establishing or altering treatment plans, treatment, examining patients, ordering diagnostic services, etc. under any other circumstances constitutes the practice of Chiropractic without a license and is the grounds for criminal malpractice in the State of Missouri and educational discipline by Logan.

- An Intern is not authorized to independently sign any documents related to patient care in the Health Centers. These records must always be co-signed by the supervising Clinician. Under no circumstances should an intern sign insurance, physical exams, notes excusing absences from work, school or gym class, or any other official document. All correspondence with health care professionals, lawyers, and insurance companies must be approved and signed by the treating Clinician.
- Logan students or Interns should never refer to themselves or fellow classmates as "Doctor" while addressing the general public or other professionals. Interns are not permitted to contact other physicians regarding their patients. This can only be done by the licensed Clinician to whom the patient is assigned.

Failure to comply with any of the Scope of Practice may result in educational discipline by Logan University.

## Purpose of Chiropractic Education

The purpose of chiropractic professional education is to provide the student with a core of knowledge in the basic and clinical sciences and related health subjects sufficient to perform the professional obligations of a Doctor of Chiropractic.

A Doctor of Chiropractic is a portal of entry physician whose purpose, as a practitioner of the healing arts, is to help meet the health needs of individual patients and of the public, giving particular attention to the structural, functional and neurological aspects of the body.

The application of science in chiropractic concerns itself with the relationship between structure, primarily the spine, and function, primarily coordinated by the nervous system of the human body, as that relationship may affect the restoration and preservation of health.

Further, this application of science in chiropractic focuses on the inherent ability of the body to heal without the use of drugs or surgery.

As a gatekeeper for direct access to the health delivery system, the Doctor of Chiropractic's responsibilities as a portal of entry physician include wellness promotion, health assessment, diagnosis and chiropractic management of the patient's health care needs. When indicated, the Doctor of Chiropractic consults with, co-manages, or refers to other health care providers.

## Practicum Objective

Logan is dedicated to the purpose of producing competent chiropractic physicians who will provide quality patient care. In doing so, Logan University's College of Chiropractic adheres to the Council on Chiropractic Education's (CCE) document outlining the "Clinical Education Meta Competencies."

A graduate of Logan University's College of Chiropractic is competent in the areas of:

### Assessment & Diagnosis (Meta-competency 1)

An assessment and diagnosis requires developed clinical reasoning skills. Clinical reasoning consists of data gathering and interpretation, hypothesis generation and testing, and critical evaluation of diagnostic strategies. It is a dynamic process that occurs before, during, and after the collection of data through history, physical examination, imaging, and laboratory tests.

### Management Plan (Meta-competency 2)

Management involves the development, implementation and documentation of a patient care plan for positively impacting a patient's health and well-being, including specific therapeutic goals and prognoses. It may include case follow-up, referral, and/or collaborative care.

### Health Promotion and Disease Prevention (Meta-competency 3)

Health promotion and disease prevention requires an understanding and application of epidemiological principles regarding the nature and identification of health issues in diverse populations and recognizes the impact of biological, chemical, behavioral, structural, psychosocial and environmental factors on general health.

### Communication and Record Keeping (Meta-competency 4)

Effective communication includes oral, written and nonverbal skills with appropriate sensitivity, clarity and control for a wide range of healthcare related activities, to include patient care, professional communication, health education, and record keeping and reporting.

### Professional Ethics and Jurisprudence (Meta-competency 5)

Professionals comply with the law and exhibit ethical behavior.

### Information and Technology (Meta-competency 6)

Information and technology literacy are manifested in an ability to locate, evaluate and integrate research and other types of evidence, including clinical experience, to explain and manage health-related issues and use emerging technologies appropriately.

### Intellectual and Professional Development (Meta-competency 7)

Intellectual and professional development is characterized by maturing values and skills in clinical practice; the seeking and application of new knowledge; and the ability to adapt to change.

These represent the minimal skills a candidate must demonstrate upon completion of the educational program with resident clinical experience in an institution that is accredited by the Commission on Accreditation of the Council on Chiropractic Education.

## Intern Duties and Responsibilities

1. Interns must realize their responsibility in obtaining all credits necessary for Health Center course completion and graduation.
2. Interns are prohibited from:
    a. Engaging in social and/or intimate relationships with patients currently under their care or within 90 days of transfer or release from care; and/or
    b. Treating patients with whom Interns have a pre-existing social and/or intimate relationship. It is the intent of Logan that this policy be construed broadly to avoid even the appearance of improper activity. Interns having doubt or concern regarding whether specific conduct or activities are ethical or otherwise appropriate should contact the Chief of Staff or his/her designate. Violation of this rule will result in punitive action and may be referred to the Professional Committee.
3. Interns must be present, available, properly attired and in possession of their diagnostic equipment for their assigned rotation shifts, patient appointments and any other activity within the clinic (including review of patient records). This should include a thermometer, stethoscope, sphygmomanometer (blood pressure cuff), penlight, combination ophthalmoscope/otoscope, reflex hammer, small tape measure, goniometer, disposable specula for ears, and hand held eye chart.
4. Interns must complete all clinic related documents and forms according to current procedures as established in this handbook or by policy.
5. Each Intern is assigned to a Clinician, interns must follow the directions and instructions of Clinicians. Advising, consultation, history taking, examining, performing or ordering studies, establishing or altering treatment plans and treating patients are the purview of the licensed Clinician. Interns may not perform any service without the consent of the Clinician responsible for the care of the patient.
6. Patients are to be gowned during examinations and treatment. Robes are available for traveling to other areas. Patients should be instructed to wear socks and shoes when walking outside the treatment room.
7. All physical therapeutics (modalities) and rehabilitation equipment must be cleaned and then returned to the appropriate storage area immediately following its use.
8. All treatment rooms must be clean and in a presentable condition prior to bringing the patient to the room. Following patient care, Logan interns are required and expected to disinfect the surfaces of the treatment table. This should be done using the disinfectant spray and paper towels that are in the treatment room. Interns are required and expected to perform this duty following every patient encounter.
9. Physical examination findings, diagnosis and/or treatment must be discussed with the clinician in charge of the care of the patient prior to discussing this with the patient.

10. Patient files or clinical records may not be removed from a Health Center for any reason, nor can a patient be seen at a different location unless the patient willingly transfers to that facility and the records are officially transferred.
11. Interns must comply with HIPAA and maintain confidentiality and privacy for their patients. Discussion with the patient regarding their diagnosis or how they are feeling must not occur in the reception area or any other public area. Absolutely no patient information (including personal notes) may be stored electronically on personal computers, or personal electronic devise and records may not be removed from the clinic.
12. Confidentiality must be maintained by Interns when discussing cases in which the patient is not present.
13. Interns must be responsible for any educational task that is assigned by any attending Clinician or the Health Center Administration.
14. Interns may not contact other physicians regarding their patients nor arrange for a referral to another health care professional. The attending Clinician along with the Intern will handle all communication with other physicians.
15. Interns may not advise patients regarding medications they are taking. Interns must obtain approval of their Clinician prior to recommending herbal, vitamin, or mineral supplements.
16. Falsifying Health Center records is a serious offense. Examples include *but are not limited to* forging signatures on the sign in/out sheets, vacation forms, patient records, travel sheets, clinical laboratory and radiology impressions, narratives and research papers. Violation is subject to Professional Committee review and may result in institutional suspension or dismissal from the program.
17. Interns are expected to treat fellow students, faculty, staff, and patients with respect. Unprofessional conduct (including negative actions, social media posting, malicious gossip, and vulgar comments) will not be tolerated. Punitive measures will be taken and the incident will be referred to the Professional Committee.
18. Interns may only use the adjusting techniques in which proficiency has been attained in the Logan specialized technique courses. Proficiency attained of an adjusting technique gained outside of Logan's curriculum, (i.e. Logan's post-graduate courses or other seminars) cannot be used while attending patients in the Logan Chiropractic Health Center System.
19. Diversified and Basic techniques are the only two adjusting techniques that can be utilized in Student Health Center.
20. Interns are to treat all patients assigned or requested of them by their Clinician. Co-treating patients to provide procedure credit to another Intern is prohibited.
21. It is important that Interns maintain a professional environment for patient care at all times. Do not loiter in the reception area, around the front desk, or the P.T./rehabilitation area.
22. No adjusting or manipulative procedure can be performed except under the present and direct supervision of a duly licensed and qualified instructor.

23. Unauthorized adjusting procedures performed either on or off campus shall subject the individual(s) to a hearing before the Professional Committee and possible dismissal from Logan College.

Other responsibilities not specified in this section or elsewhere in this handbook, may be outlined for students by Clinicians or Health Center Administration and in the regular Logan Student Handbook.

## Health Center Locations

The following is a list of all Health Centers within the Logan Chiropractic Health Center System with directions to each location.

### Montgomery Health Center

1851 Schoettler Road
P.O. Box 1065
Chesterfield, MO 63006-1065
(636) 227-0903 (636) 207-2404 (Fax)

| | |
|---|---|
| Monday—Thursday | 11:30 am—7:00 pm |
| Friday | 11:30 am—6:00 pm |
| Saturday | 9:00 am—12 Noon |

The Health Center is located on the campus of Logan College and was opened to the public in March 1982.

### BioFreeze Center

1851 Schoettler Road
P.O. Box 1065
Chesterfield, MO 63006-1065
(636) 227-0903 (636) 207-2404 (Fax)

| | |
|---|---|
| Monday—Thursday | 11:30 am—7:00 pm |
| Friday | 11:30 am—6:00 pm |
| Saturday | 9:00 am—12 Noon |

The BioFreeze Center is located on campus and specializes in sports injuries and rehabilitation.

### Bogey Hills Health Center

2067 Zumbehl Road
St. Charles, MO 63303
(636) 947-4770 (636) 947-8988 (Fax)

| | |
|---|---|
| Monday—Thursday | 11:30 am—7:00 pm |
| Friday | 11:30 am—6:00 pm |
| Saturday | 9:00 am—12 Noon |

This Health Center opened in January 1993. From campus, take Highway 40/64 east to Interstate 270 North and go west on Interstate 70, and cross over the Missouri River. The 3rd exit is Zumbehl Road, turn left on Zumbehl Road, cross over the interstate, and the Bogey Hills Shopping Plaza can be seen on your right.

### Southfield Health Center

5422 S. Lindberg Blvd.
St. Louis, MO 63123
(314) 849-3800 (314) 849-5986 (Fax)

| | |
|---|---|
| Monday—Thursday | 11:30 am—7:00 pm |
| Friday | 11:30 am —6:00 pm |
| Saturday | 9:00 am—12 Noon |

This is Logan's newest Health Center opened in August 2011. From the campus, take Highway 40/64 east to I-270 south. Drive 10.4 miles and take MO-21 Exit 2. Turn left onto Tesson Ferry Road. Within one mile, turn left onto Baptist Church Road. Go 0.4 of a mile and turn right onto S. Lindberg Blvd. Southfield Center is on the immediate left.

### 79 Crossing Health Center

263 Salt Lick Road
St. Peters, MO 63376
(636) 397-3545 (636) 397-3560 (Fax)

| | |
|---|---|
| Monday—Thursday | 11:30 am—7:00 pm |
| Friday | 11:30 am —6:00 pm |
| Saturday | 9:00 am—12 Noon |

This Health Center opened in October 2003 and was relocated in August 2008. From campus take Highway 40/64 west approximately 12 miles to MO Highway K. Go north on Highway K approximately 6.3 miles and merge onto I-70 Eastbound. Exit I-70 at MO-79 (exit 220) and turn right onto Salt Lick Road. The Health Center is located in the 79 Crossing Center.

### Adult Rehabilitation Center

3949 Forest Park Blvd.
St. Louis, MO 63117
(314) 535-0057 (636) 397-3560 (Fax)

Monday & Wednesday 6:30 pm—11:00 pm

The ARC facility opened in August 1993 and is located in a facility owned and operated by the Salvation Army. It is a rehabilitation center for chemically and alcohol dependent adult men. Residents are seen free of charge on Monday and Wednesday evenings. From campus drive east on 64/40 to the Vandeventer/Chouteau exit. Follow the Vandeventer exit ramp to the stoplight. Take a left at the stoplight onto Vandeventer. Drive to the first stop light. Take a left onto Forest Park Boulevard. A.R.C. is one block west on the right side of the street. Interns can park in the parking lot just west of the building.

### St. Patrick's Center

800 N. Tucker Blvd.
St. Louis, MO 63101
(314) 436-6971 (314) 436-0135 (Fax)

Monday—Friday 9:30 am—4:30 pm

This Logan Health Center is located within the St. Patrick's Center and is a free community service facility. The Health Center opened in May, 2003. From campus, go east on Highway 40 to the 11th Street exit (exit number 39C) on the left toward Stadium. Turn Left on Clark St. and turn Right on to N. Tucker Blvd. You will find the facility approximately ½ mile down on your right. Park across the street from the building in the rear fenced lot.

### Veteran's Administration Medical Center

St. Louis VA Medical Center
Jefferson Barracks Division
Building #52, Room #2S13
1 Jefferson Barracks Drive
St. Louis, MO 63125
(314) 652-4100 ext. 66369

Monday, Thursday, Friday
8:00 am—4:30 pm

This Logan Health Center is located within the Veteran's Administration Jefferson Barracks compound. The Health Center opened in October, 2005. From campus, go east on Highway 40 to Highway 270 south. After passing over Highway 55 in the south county area, Highway 270 turns into Highway 255. Take this to the Koch Road exit, turn left onto Koch Road and proceed to the VA entrance. Proceed to Building #52, second floor.

### Scott Air Force Base Rotation

310 W. Losey
Scott AFB, IL 62225
618-256-7102

Monday - Friday
7:30 am—4:30 pm

The Clinic is located within the Scott Air force Base compound. From campus, go east on Highway 40 for 23 miles crossing into Illinois. Take Exit 2 toward Louisville/IL-3 N/St. Clair Avenue (16 miles). Turn left of Wherry Rd, then take a right onto Scott School Road which becomes Pryor Drive. Turn left on Ware St., turn left onto Scott Lake Road. Before scheduling a visit to Scott AFB, please contact the Chiropractic Clinic at 618-256-7102.

### CHIPs

2431 N. Grand Blvd.
St. Louis, MO 63106-1018
314-652-9231 ext. 10

Tuesday
12:30 pm—4:30 pm

From campus, take Schoettler Road to I-64/US-40 toward St. Louis. Take US-40 (17.4 miles) to the left. Grand Blvd. exit, Exit 37B. Take a slight right to S. Grand Blvd. (1.6 miles) which will become N. Grand, 2431 N. Grand Blvd. is on the

### Paraquad

5240 Oakland Avenue
St. Louis, MO
314-289-4200

Wednesday and Thursday
12:30 pm -5:30 pm

Paraquad is a nonprofit organization whose mission is to empower people with disabilities to increase their independence through choice and opportunity - See more at: http://www.paraquad.org/about-paraquad.

Paraquad is located on the south side of Interstate 64 (Highway 40) between the Hampton Ave./Oakland Ave. and Kingshighway Blvd. exits. The St. Louis Science Center is to our east, and Forest Park Community College is just west of us.

### Student Health Center

1851 Schoettler Road
P.O. Box 1065
Chesterfield, MO 63006-1065
(636) 227-2100 ext. 329
(located in back area of Montgomery Health Center)

| | |
|---|---|
| Monday—Thursday | 11:30 am—1:00 pm |
| and | 3:45 pm—6:45 pm |
| Friday | 2:45 pm—6:00 pm |
| Saturday | 9:00 am—12 Noon |

This Health Center, located on the main campus in Chesterfield, serves the chiropractic needs of Logan students and their families.

## Closure Due To Weather

In the event of inclement weather conditions, the clinics may close early or close for the day.

> IMPORTANT - the canceling of classes does NOT mean the clinics have closed or that Intern rotation and patient assignments are canceled. Due to the nature of patient care, the Health Center System operates differently than the academic system of Logan.

If the Health Centers close due to inclement weather, Health Center personnel will contact patients for cancellations/rescheduling. The following radio station will announce the closure of Logan and the Health Centers: KMOX 1120 AM. On television, such announcements can be found on KTVI Fox Channel 2 (www.myfoxstl.com) and KSDK News Channel 5 (www.ksdk.com). Notification will occur with Logan's e2 Connect System.

## Holiday Schedule

The Health Center System is closed six (6) days during the year as follows:

1. New Years Day
2. Memorial Day
3. Independence Day
4. Labor Day
5. Thanksgiving Day
6. Christmas Day

The Health Center will also close for graduations and other, to be announced, special functions.

# Health Center Policies and Overview

## Health Center Assignment

Intern assignments for all clinics start with a lottery-based selection process. This process is initiated in Trimester 4 and Interns are encouraged to visit all Health Centers prior to the lottery. After the clinic assignment is selected, there will be no changes. The Health Center Administration directs this process and has the final decision for all Intern assignments. The intern rotation and shift assignment schedule is available on Self-Service and is posted for the upcoming trimester 4 weeks prior to the first day of finals. (In addition, Trimester 8 Interns receive rotations at the Adult Rehabilitation Center (A.R.C.). Trimester 8, 9, and 10 Interns receive rotations at St. Patrick's Center.)

Interns will be assigned 3, four hour shifts per week at their assigned clinic. Clinic shifts are from 11:30 a.m. – 3:30 p.m. and 3:00 p.m. – 7:00 p.m. All new patient, adjustment credits and assessed activities must be obtained from the intern's assigned clinic. This refers to the intern's selected fee for service clinic. In addition, interns that are "assigned" rotations through the ARC and St. Patrick Center can apply credits from those sites for Type II patients on the date they have been assigned towards their graduation requirements.

Interns that have applied for and been selected to serve as Coordinators at these sites will have their "assigned shift" as coordinator serve as an assigned shift. As a result, any clinical activities performed on these assigned shifts will be credited towards their graduation requirements in the Type II patient category.

## Recording Intern Credits

The number of adjustment, physical examinations, physiological therapeutic treatments, and all other clinic requirements are tracked by Health Center personnel. The clinical requirements needed for graduation are updated daily. Accumulated totals for each Intern are published on a weekly basis and made available to all Interns via the Health Center Web based intern data tracking system. All 10 of the new patient credits and all 200 of the adjusting credits required for graduation MUST come from the intern's assigned clinic.

### Verification of Clinic Hours Worked

Interns are required to sign in/out using the fingerprint tracking system that is located at each fee for service clinic site. At the Community service clinics, interns should sign in/out on the attendance sheet at that site. When an Intern signs in, it indicates that the Intern is present, properly dressed, equipped, and available to treat patients. It is considered unprofessional for Interns to sign in and not be available. Likewise, it is unprofessional for Interns to sign out early. Credit is given only to Interns who sign in and remain available for the entire duration of their shift. Please be advised that the public address system cannot be heard in the library and some other areas at Logan. Interns will not be contacted on personal pagers by the front desk.

## Health Center Grades

Evaluation and grading are performed by the Intern's assigned Health Center Clinician and is based upon all aspects of the Intern's demonstrated clinical competencies. It is the student's responsibility to demonstrate these skills and maintain sufficient contact with their assigned Clinician to facilitate evaluation on these parameters. Failure to do this will reflect in your grade.

If, in the opinion of a Clinician, an Intern demonstrates a lack of proficiency in the performance of any aspect of their clinical duties (consultation/patient history, patient examination, differential diagnosis, adjusting or other patient care procedures), the Intern may be referred to the Director of Clinical Education for integration into an Individualized Educational Plan with specific recommendations from the Clinician and Health Center Administration.

The Health Center Practicum is comprised of three separate trimesters, each with specific requirements outlined in the syllabus posted on self serve. Each trimester is graded as a Pass or Fail.

## Fees for Interns

The Health Center fee is intended to cover any incidental costs incurred by the Interns during their six Trimesters of Health Center education at Logan College. This fee covers such items as I.D. badges, malpractice insurance coverage, handbook, and business cards. The fee of $170.00 will be divided into 2 payments of $85.00 that will be charged to the Intern's account at the beginning of Trimesters 5 and 8. The intern is responsible for maintaining his or her intern I.D. badge. If lost or defaced it is at the intern's additional expense to have it replaced. A current I.D. badge must be worn to receive daily shift credit.

## Senior Intern Assistant Program

The Senior Intern Assistant Program enables motivated senior Interns to work in the Health Center System for personal and clinical skills enhancement. Interns interested in this program should speak with their Clinician regarding participation. Interns on academic probation are not eligible and participation is contingent upon continued fulfillment of both academic and consultation responsibilities.

Benefits of participation in the program include:

1. Interns are recognized with a certificate at the Tri 10 awards ceremony.
2. Additional clinical experience from working closely with an experienced Clinician.
3. Additional experience in patient management while working with a licensed Clinician and treating Interns.

Prerequisites:

1. Work study eligibility as determined by the Financial Aid office;

2. Minimum grade point average (cumulative) of 2.5; and
3. Recommendation from assigned Clinician.

Responsibilities of a Senior Intern Assistant:

1. Assists Interns with new patients in all functions such as consultation, case history, review of findings, physical examination, report of findings, development of a treatment plan, as well as the processes associated with patient examination and ordering x-rays and clinical laboratory work.
2. Aids licensed Clinician with assisting Intern's utilization of physical therapy, and Intern record keeping.
3. Assists in case reviews and review of patient records prior to Clinician review.

## Group Leader Program

The Group Leader Program is designed to provide assistance to interns during the initial phase of outpatient clinic activities. Interns to be designated as Group Leaders are selected by their assigned clinician to serve in this capacity. The Group Leader is on "the floor" at all times and is at the disposal of the interns to assist as needed. The Group Leader will observe and assist the newer interns with patient intake procedures, documentation of the encounter, differential diagnosis strategies, treatment plan development, future scheduling, EMR system, and completion of insurance reporting forms. In addition, the Group Leaders are to observe and assess the Report of Findings delivered to the patients by the interns. Any and all documents completed by the intern and Group Leader must be reviewed and approved by the Clinician. Intern performance in these various activities is assessed by the Group Leader and the strengths and weaknesses in the different tasks are reported back to the Clinician for review with the intern. Group leader training is done by the Clinician.

## Attendance Policy

Attendance at the Health Center is important for the appropriate delivery of patient care and to ensure Intern education. Our patients depend upon Interns for quality consistent care.

Interruption of 15 weeks or more in the sequence of Trimester 7 through 9 Health Center courses will require that the intern go through the Proficiency I Exam. The student will be required to pass the Proficiency I Exam again, prior to reinstatement of privileges in the Health Centers. Interruption of 15 weeks or more during the Trimester 10 course will require the intern to retake, and pass, the Proficiency II Exam.

The shift assignments include rotations at the Adult Rehabilitation Center (A.R.C.) and St. Patrick's Center for Trimester 8 Interns. Trimester 9 Interns will have shift assignments at St. Patrick's Center. Trimester 10 Interns will have shift assignments at St. Patrick's Center. These clinics provide Interns with an opportunity to treat patients not typically seen in the other clinics.

If necessary, an Intern may transfer their St. Patrick's Center or A.R.C. rotation to another eligible Intern. The intern must send an email to the clinician at the involved clinic, copy the Chief of Staff, and the intern taking their shift. The intern taking the shift must respond via email and indicate their agreement and commitment to taking the shift. Interns taking another intern's shift that is in conflict with their own regular shift schedule will be required to use one of the allotted cut days. Attendance at the assigned clinic rotation is mandatory for all Trimester 8, 9 and 10 Interns. Trimester 10 Interns will continue their assigned clinic rotation until they depart for preceptorship. If an Intern misses an assigned shift at the primary clinic, the Intern will be suspended for two (2) weeks.

When under suspension, the Intern must be present for all assigned shifts, scheduled patient appointments, and maintain the patient treatment plan, but will not receive credit for any clinical activities or hours performed during the duration of the suspension.

Failure to present for an assigned shift without notification of clinic staff may result in suspension. Suspension may be for up to two weeks and may result in the loss of hours and credit for clinic activities performed during the duration of the suspension.

If an Intern misses an assigned or voluntary shift at any site, the Intern faces suspension in accordance with the policies listed in the violations section of the handbook. Interns will not receive clinic hours while they attend Board review sessions.

It is considered unprofessional for Interns to arrive late for their rotation shift or leave early, however, the Clinician may give approval for advance Intern requests. Verification of attendance is based on the sign in/out sheets at all clinics. Interns will not receive credit for clinic hours if they fail to print/sign at the beginning of their shift or print/sign out after completing work in the community service clinics.

The fingerprint/WASP verification will be used to verify hours at St. Peters, Bogey, Montgomery and Southfield Clinics.

While working at a Health Center, all Interns need to:

1. Check in and sign the attendance sheet at the front desk at the beginning of their shift, sign out at the end of the shift.

   Failure to do so will result in an absence for that shift.

2. Finger print verification in and out at the beginning and end of their shift.

   Failure to do so will result in loss of credit for hours worked.

## Vacations/Sick Time/Absences

The first day an Intern is required to begin working in outpatient clinic is two weeks after the first day of finals in Trimester 7. Because this is the first official day of Trimester 8, the vacation/absence rule begins on this day. The rule stipulates that an Intern is entitled to:

- Six (6) absences each trimester. The trimester begins the first day of finals. The tri8 class will have a two week break before entering clinic and start two weeks after their Trimester 7 finals.
- The Intern must notify his/her clinician, and the front desk staff, by email, in advance of any planned absence. If sick, the intern must call the clinician or front desk prior to their shift and report that they will not be in the clinic that day. Attendance by the covering Intern is mandatory for all assigned clinical rotations and for all scheduled patients under the scheduled Intern's care.
- In the event of illness, Interns may be examined to insure that they are well enough to treat patients. Sick days or other absences shall apply to the six allowed per trimester.
- Because of the importance of adhering to treatment plans, patient visits can't be rescheduled for Intern convenience. This is especially important around finals, holidays, and national boards. Many patients are lost when Interns reschedule appointments. Patients are to schedule appointments with the individual health centers front desk business staff. All patient cancellations are to be completed by the front business desk along with patient appointments.

Absence or late arrival should be phoned into the Health Center Administration before the assigned shift begins (i.e. car trouble, etc.). Absences due to National Board examinations and participation in clinic-sanctioned events will not count toward an absence. Requests for scheduled absences for such events must be submitted at least one (1) week in advance.

## Dress Code

The Intern's demeanor and attire directly impact your patients immediate impression of you as a professional. Interns are urged to dress in sharp, clean, pressed clinical attire. Clinical attire is to be worn only in the clinics.

Please consider the patient's point of view regarding this matter. Interns are encouraged to consider their expectations of a doctor. The general public expects doctors to dress and act in a professional manner. A professionally-dressed doctor readily gains a patient's respect. Therefore, Interns are expected to be in professional attire while in any Health Center. Professional appearance includes appropriate hygiene and grooming when engaged in any aspect of clinic activity, patient care, or community contact involving your representation of Logan University and the profession. Interns are encouraged not to smoke.

After successful completion of all clinic pre-requisites and subsequent entrance into the out-patient Health Center System, Interns will receive a Logan emblem. The Logan College Alumni Association provides a complimentary emblem to each Intern as a means of recognizing and congratulating Logan Interns upon reaching this very important milestone in their chiropractic education.

The emblem displays the Logan logo and identifies the Intern as having attained a level of academic and clinical proficiency. It also distinguishes senior or out-patient Interns from individuals in the student health center. The emblem should be sewn on the left breast pocket area of the Intern's clinic jacket. Non-compliance prohibits further clinic progression. Additional emblems are available for purchase in the bookstore.

Pictures for ID badges are taken by the Audio-Visual Center after Interns successfully complete the Competency Boards. These badges are to be returned to the Registrar during an Intern's final check-out prior to graduation. As noted previously, if an intern loses or defaces his or her badge the replacement charge is $25.

For both male and female Interns, professional attire includes wearing a white, hip-length jacket that is ironed and clean. Interns must wear their nametag on their jacket and the breast pocket must bear the embroidered Logan patch. No other badges, nametags, or buttons are permitted. Sport jackets and suit jackets are not acceptable substitutes for the clinic jacket. Proper clinical attire is required in all areas of each health center including Biofreeze Human Performance Centers.

Business attire is appropriate to wear underneath the clinic jacket. No denim trousers, skirts, or dresses are permitted. Closed dress shoes are required (with moderate heel height for the female Interns). Black tennis-type shoes are not acceptable.

Male Interns must wear dress slacks, a dress shirt, and a tie (closed at the collar), and must be cleanly groomed. Facial hair is permitted as long as the mustache or beard is neatly trimmed. Interns wishing to grow a beard need to do so during vacation and not during times when they are active in the clinic. Light-weight sheer shirts are allowed only if the Intern wears a tee-shirt underneath.

Female Interns: Miniskirts, Capri pants, shorts, leggings, spandex, spaghetti straps, crop tops (midriffs), sheer see-through blouses, and other revealing attire are not acceptable. Clothing must not be so tight as to prevent freedom of movement during the delivery of chiropractic services.

Long hair must be secured to prevent hanging over the patient's face during adjustment. All body piercing jewelry (except earrings for female Interns) must be removed from the face and mouth. Multiple earrings throughout the earlobe are not allowed. Perfume or cologne, excessive make-up, jewelry, and extremes in style are not acceptable. Interns are expected to pay special attention to their hands and to ensure well-trimmed (to a moderate length for female Interns) and clean nails.

Interns performing any functions within the clinic related to patient care, documentation and/or the educational program must comply with the dress code. Any Intern who presents in the clinic not in compliance with the professional attire requirement as outlined above may be asked to leave the clinic and not return until properly dressed. Final decision of the suitability of the attire is made by the Clinician.

## Professional Behavior

Professional conduct and dress are expected of all students, Interns, faculty and staff when in any of the Health Centers. Professional conduct is a demeanor that is pleasant and respectful and includes consideration for a patient's time and comfort. Interns should introduce other Interns who work with them during patient care. Treatment room doors should be closed at all times during patient care and Interns should be sensitive to maintaining modesty for all patients. Maintaining a clean and professional environment impresses patients, demonstrates your respect for patients and encourages referrals.

Professional dress is defined as clean, ironed, neat business attire. (See the Health Center Dress Code Policy, page 22, for more details.) Remember, first impressions are very important and affect patient care. Your physical presentation is the first chance Interns have to gain the confidence of a patient. Interns who are studying, practicing radiology positioning, practicing with P.T. equipment, or just working on patient files must also be professionally attired.

Interns are asked to avoid the following activities to allow for the maintenance of a professional environment:

- Do not occupy a Clinician's office when the Clinician is not present, or 'hang out' while other Interns and the Clinician are working. Please use the Intern lounge when not involved in patient care.
- Interns are not permitted to use the clinic telephones, desks, or copiers in the Health Centers.
- Patients should not be taken into a Clinician's office without first obtaining the approval of the Clinician to do so.
- Interns are not to congregate around the front desk.
- Interns shall not discuss grievances with the front desk personnel or employees of Logan in front of patients or in a public setting. Please speak privately with the person involved.
- Do not discuss patient information, well-being, treatment plans etc. with a patient in a public setting (hallway, waiting room, front desk) and anywhere outside of Logan. This is a breach of patient confidentiality and is in violation of HIPAA compliance.
- Interns are not to loiter in the hallways as this creates an unprofessional appearance.
- Disrespectful behavior towards any person (present or not present) in the Health Centers. Negative, malicious, integrity impugning, and vulgar comments or social media postings, or actions will be deemed unprofessional and result in punitive measures and referral to the Professional Committee.

- Interns may not receive personal phone calls while working in the Health Centers except in the event of an emergency. Interns should direct patients, friends, and family to leave a message with front desk staff.

### Emergency situations

In the event of an emergency situation Logan's E2 Connect System will be activated. In the event of a weather or other emergency, lockdown, etc., interns will adhere to supervisor directives. If an employee and/or student is/are off campus at another facility for a sponsored event or function, the employee and/or student will follow the directives given by the authority responsible.

## Prohibition of Alcohol/Drugs

In addition to established drug abuse and prevention policies, Logan prohibits the use of alcohol for at least eight (8) hours prior to any aspect of patient care. This includes any time while signed in at a Health Center, while on any assigned rotation, emergency calls, or events sponsored by the Health Center. The use of illegal drugs or controlled substances is strictly prohibited at any time. Violation of this policy will result in suspension of clinic privileges without appeal for a minimum of one Trimester equivalent (15 weeks) and referral to the Professional Committee. Students will be referred to an appropriate center for evaluation at the student's expense. Repeated violations will result in expulsion from Logan.

Application for resumption of clinical privileges or re-admission must be accompanied by a written evaluation from a treatment facility/program for consideration by the Professional Committee. Re-admission will be granted only with the approval of the President, based upon recommendation of the appropriate committee.

Interns that are on clinical rotations or have any patient contact should exercise professional judgment if they believe they are in violation of the eight (8) hour limit or have previously ingested a sufficient amount of alcohol/drugs to impair their judgment and actions, or if a student believes they would test positive upon testing. These drugs include prescription drugs that can affect the Intern's ability to function professionally. If impaired, students should call in sick/absent to the Health Center. This will be counted as an absence.

Clinicians can require a student to submit to alcohol/drug testing if there is reasonable suspicion of alcohol or drug use (smell of alcohol, physical appearance, behavior etc.). Refusal to submit to immediate testing will result in an immediate suspension of all clinical privileges for the equivalent of one Trimester (15 weeks) without appeal and with referral to the Professional Committee. All allegations, refusals, and positive test results will be documented and entered into the student's permanent record.

A second incident with a positive alcohol or drug test results or refusal to submit for testing will result in dismissal from Logan.

## Concealed Weapons Policy

Logan does not, under ***any*** circumstances, consent to the carrying of a concealed weapon on its property, or to having a concealed weapon in a vehicle while parked on Logan property (including all Logan Health Centers). Any violation of this policy or any refusal to allow the Logan to search and/or inspect your person, your belongings, or your vehicle while on Logan property will result in discipline up to and including suspension, expulsion, or removal from the premises.

## Equipment and Supplies

All supplies are ordered by the Health Center Administration. Interns must report equipment malfunction as soon as possible to the SIA, GL or Clinician. Please submit the problem in writing with a description and location of the equipment. Equipment includes adjusting tables, stools, P.T. machines, etc.

- Clean gowns and towels are at the front desk when the Intern greets the patient. Interns should place the soiled items in the hampers provided in each hallway of the satellite clinics.
- Head rest paper can be obtained from the front desk staff. Interns must change the face paper after each patient. Following patient care, interns are required to disinfect the surfaces of the treatment table that patients come into contact with. This should be done using the disinfectant spray and paper towels that are in the treatment room. Interns are required to perform this duty after every patient encounter.
- A clean and straightened treatment room makes a patient feel comfortable and leaves a good impression.

Please note: It is the Intern's responsibility to keep the Health Center patient care areas neat and clean. Cooperation and respect for others is vital to managing a prosperous business.

## Communicable Disease Policy

Students, staff or other health care professionals diagnosed with a communicable disease such as tuberculosis, chicken pox, measles, etc. cannot be in attendance for class or any Health Center function. Those infected with a communicable disease cannot return to class or clinic duties until deemed non-infectious. This is in accordance with guidelines published by the Missouri Board of Health. No employee or student will be excluded from treatment in the clinic during this period.

## Infectious Disease Control Policy

The purpose of this policy is the control of infectious disease transmission and to establish appropriate guidelines for the handling of potentially infectious contaminants.

All employees shall use blood and body fluid precautions when caring for all patients, whether known to be infectious or not, using the following guidelines:

1. Hands shall be washed before and after each patient contact and before gloving.

2. Gloves shall be worn for all contact with every patient as follows:
    a. Any contact with blood and body fluids, mucous membranes or non-intact skin;
    b. Handling items or surfaces soiled with blood or body fluids;
    c. Performing venipuncture and/or other vascular access procedures; and
    d. When treating known infected individuals.
3. Gloves shall be removed after contact with each patient. Hands shall be washed immediately after removing gloves. Gloves and other materials shall be discarded in a marked plastic lined biohazard container.
4. Hands and other skin surfaces shall be washed immediately and thoroughly if contaminated with blood or other body fluids.
5. Gowns are to be worn if clothes are likely to be soiled with blood or body fluids.
6. Needles shall not be recapped, purposely bent, broken by hand or removed from disposable syringes. After usage, they shall be placed in a puncture resistant container for disposal.
7. **In patient care areas, spills of blood and other body fluids shall first be thoroughly cleaned using a detergent. Then the area shall be decontaminated using an approved germicide, i.e. 70% alcohol or a 1:10 dilution of household bleach and water. All contaminants shall be placed in a marked biohazard container. The Clinician and Director of Clinical Services are to be notified immediately of any needle punctures or blood loss at any of Logan's Health Center Facilities.**

### Respiratory Precautions

When treating a patient with a respiratory communicable disease, Interns are advised to keep treatment room doors closed, and to wear masks. Interns are to wash hands before and after patient care and any material contaminated by secretions from the patient is to be properly disinfected and discarded in a marked biohazard container. Treatment table must be disinfected following patient care.

### Wound and Skin Precautions

Interns are to treat patients with exposed wounds and skin ailments in a private room and wear a gown when treating the patient. Masks are to be worn if changing a dressing on a wound. Hands must be washed before and after patient care, and gloves worn during patient care. Gowns are to be double bagged in plastic bags and all equipment and tables disinfected. The procedure follows the Logan blood borne pathogen policy.

## Performance of Pelvic/Gynecological Examinations

Logan Health Centers do not offer patients pelvic examinations of either the speculum or bimanual variety. Logan does not perform pap smears on patients. However, Interns are taught the indications and technique for these procedures.

To satisfy specific state requirements, Interns must perform 10 pelvic examinations on models prior to graduation. These are performed in the Physical Diagnosis classes and credit is transferred to the Terms Transcript. This is in compliance to select state examining board requirements.

Logan Health Centers strongly advocates breast self-examination procedures. Logan Health Centers offer education regarding breast self exams. Interns are trained in this educational process and may engage in such education with patients under the supervision of a Clinician with the use of a breast model utilized as a teaching modality.

## Performance of Rectal Examinations

To satisfy specific state requirements, Interns are required to perform 10 rectal examinations on models prior to graduation. These are performed in the Physical Diagnosis classes and credit is transferred to the intern's official transcript.

## Patient Category

Two types of patient visits are tracked through the clinic experience. The first group is regular, paying patients (designated as "TYPE I") seen in our fee for service clinics. Student interns are required to see a minimum of 100 TYPE I patients.

**Scott Air Force Base patients are included in the group, as interns assigned to Scott are not assigned to a fee for service clinic.

The second group is patients seen in our community service and public relations (designated as "TYPE II") facilities, as well as patients seen at no charge in our fee for service clinics. This group consists of:

1. 1st Responder Program patients
2. Patients seen at outside BioFreeze events such as track meets, etc.
3. Patients seen at the University of Missouri
4. Patients seen at the Veteran's Administration Hospital
5. Paraquad patients
6. St. Patrick's Center patients
7. Adult Rehabilitation Center patients
8. McCluer High School "Bumps and Bruises Clinic" patients
9. Community Health In Partnership Services (CHIPS) patients
10. Patients seen at Lindenwood University
11. Patients seen at Missouri Baptist University
12. Patients seen at St. Charles Community College
13. Logan staff, faculty and family
14. Logan Alumni

Student and student family patients are**

1. Mother/Father /Sister/Brother of a Logan student
2. Spouse/significant other of a Logan student
3. Child of a Logan student

** **Interns are prohibited from providing care to their own family members**

## First Responders Program

Logan Chiropractic Health Centers offer chiropractic care at no cost to Emergency First Responders. These are considered community service patients (TYPE II) and include members of Police Departments (officers, detectives, and staff), Correctional officers and their staff, Fire Departments (firefighters and support staff), and EMTs (field responders and support staff), and returning Post 9/11/01 military. The care includes routine, injury, and accident care and care is provided at no charge to the first responder. The only cost to members of this group will be for items such as orthopedic devices, pillows, and nutritional supplements. Care is not dependent on which municipality or private entity that the first responder is employed by. To qualify for this program, the first responder must provide proof of employment (current badge, ID card) that identifies their place of employment which shall be kept as a point of reference and placed into the patient's permanent file.

## Current Billing Classifications

Outpatient Fees (subject to change)

| | |
|---|---|
| Initial Workup (includes comprehensive health history, physical and regional examination) | $40.00 |
| Regular Office Visit – may include consultation, brief exam, adjustment<br>Extremity | $27.00 (98940)<br>$36.00 (98941)<br>$10.00 (98943) |
| Physical Therapy | $5.00 - $15.00 |
| Rehabilitation | $5.00 - $15.00 |
| Re-examination | $20.00 |
| X-rays | $45-75 per series |
| Interpretation of additional x-rays | Full price |
| Nutrition and Orthopedic products | Price marked |
| Additional Laboratory services | Full price |
| School Physicals (elementary and high school) | $15.00 |
| Adult/College Physicals | $25.00 |

**Logan Students**

| | Seen In Student Health Center | Seen in an Out Patient Clinic |
|---|---|---|
| Initial visit package | Free | Full Price |
| Re-examination | Free | Full Price |
| Chiropractic Adjustments | Free | Full Price |
| Physical Therapy | 50% discount | Full Price |
| Additional X-rays | 50% discount | Full Price |
| X-ray Interpretation | Free | Full Price |
| Nutrition and Orthopedic | 15% above cost | Full Price |
| Additional in-house laboratory | 50% discount | Full Price |
| Outside laboratory | Full price | Full Price |

**Student Family**

| | Seen in Student Health Center | Seen in an Out Patient Clinic |
|---|---|---|
| Initial visit package | Free | Full Price |
| Re-examination | Free | Full Price |
| Chiropractic Adjustments | Free | Full Price |
| Physical Therapy | 50% discount | Full Price |
| Additional X-rays | 50% discount | Full Price |
| X-ray Interpretation | Free | Full Price |
| Nutrition and Orthopedic | 15% above cost | Full Price |
| Additional in-house laboratory | 50% discount | Full Price |
| Outside laboratory | Full Price | Full Price |

**College Plan Package**

| | |
|---|---|
| Initial visit package | $40.00 |
| Re-examination | Follow up exams $10 to $20 (re-examination) |
| Chiropractic Adjustments | $7.00 |
| Extremity Adjustments | $3.00 |
| Physical Therapy | $5.00 - $15.00 |

| | |
|---|---|
| X-rays | 50% discount ($45-$75 per series) |
| Nutrition and Orthopedic | Price marked |
| Additional in-house laboratory | Full Price |
| Outside laboratory | Full Price |

**Employee Benefit Package**

| | |
|---|---|
| Initial visit package-consultation/exam/ROF | Free |
| Re-examination | Free |
| Chiropractic Adjustments | Free |
| Physical Therapy | Free |
| Rehab Therapy | Free |
| X-rays / Interpretation | Free- up to 2 series / year |
| Diagnostic Ultrasound | Free |
| Nutrition and Orthopedic Supports | Price marked |
| Laboratory services | Full Price |

**Alumni and Field Doctors (D.C.s)**

All Alumni and Field Doctor discounts apply ONLY if that person is being treated by a student Intern and that Intern and his/her Clinician request the service(s). If Alumni/Field Doctors refer themselves for radiology or laboratory services, they will be charged the full fee through the Field Doctor Program.

| | |
|---|---|
| Initial visit package | Free |
| Re-examination | Free |
| Chiropractic Adjustments | Free |
| Physical Therapy | $5 |
| Additional X-rays | 50% discount |
| X-ray Interpretation | 50% discount |
| Nutrition and Orthopedic | Price marked |
| Additional in-house laboratory | 50% discount |
| Outside laboratory | Full price |
| Rehab Therapy | $7.50 (up to 15 minutes) |

**Children 17 years of age and under**

| | |
|---|---|
| Examination | $40.00 |
| Chiropractic Adjustments | $7.00 |
| Physical Therapy | $5 |
| X-rays | 50% discount $45-75 per series |
| | |
| Nutrition and Orthopedic | Price marked |
| Additional in-house laboratory | Full price |
| Outside laboratory | Full price |
| Re-exam | $ 10 (each time) |
| Rehab Therapy | $7.50 (up to 15 minutes) |

## Financial Conflict of Interest

This policy safeguards the integrity and reputation of Logan University and the College of Chiropractic, Logan Chiropractic Health Centers and their clinical staff and Interns by fostering the proper and unbiased conduct of all clinical staff activities.

A financial Conflict of Interest arises when there is a divergence between an individual's private interests and his/her professional obligations to Logan, other staff, patients, Interns, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of financial gain. A conflict of interest depends on the situation and not the character of the individual.

Clinic staff and Interns must conduct their affairs so as to avoid or minimize financial conflicts of interest, and must respond appropriately when such conflicts arise. The following are representative, but not all inclusive, of financial conflict of interest situations:

1. Granting gifts, special favors, or unwarranted benefits to any patient or prospective patient, including, but not limited to payment of all or part of a patient's bill, offering discounted services or fees to patients and prospective patients, and/or offering any other form of inducement to patients and prospective patients;
2. Accepting gifts of monetary value from patients, prospective patients, clients, members of the public, or vendors;
3. Accepting gifts that imply forgiveness of a debt or creating an expectation of special service or benefits that would not otherwise be provided from any patient, prospective patient, client, member of the public, and/or vendor;

4. Engaging in or encouraging patients or prospective patients to enter into financial transactions with the provider, including, but limited to, investment opportunities, joint ventures, and other business transactions; or
5. Treating a patient or attempting to recruit a patient with whom the provider has a pre-existing business or similar financial relationship.

### Violation of Financial Conflict of Interest

Violations of this policy will constitute a violation of the Student Honor Code and may result in disciplinary action, up to and including professional probation, suspension, and/or expulsion from the Chiropractic Health Center and Logan University's College of Chiropractic.

## Violation of Health Center Policies

Participation as an Intern in the Health Center Systems is a privilege and carries professional, legal and ethical responsibilities. Accountability is important in the health care delivery system and in the representation of Logan and the Chiropractic profession. Health Center policies and regulations establish guidelines for professional conduct during patient care procedures, business operations, and academic protocol. Failure to adhere to policies and procedures impairs the functioning of the Health Centers and ultimately the well being of the patient. Interns cited for violations of Health Center guidelines may be required to appear before the Health Center Administration to determine the action to be taken. Appeals pursuant to disciplinary action will be directed to the College Professional Committee for final determination of action.

Actions that constitute violations include, but are not restricted to the following:

1. Any incident of insubordination with respect to a Clinician or Health Center Administration.
2. Non-compliance with a direct order of a Clinician.
3. Performance of any treatment or diagnostics, changes in plan of care or advisement of patients without prior permission of a Clinician, including treatment outside of Logan Health System.
4. Failure to follow clinic protocols as defined by the Handbook, Clinician or Health Center Administration.
5. Use of unauthorized treatment techniques or procedures during patient care (these include treatment techniques or procedures not taught at Logan or any technique where proficiency is attained outside of Logan's curriculum or through approved Logan Post-Graduate certification programs.
6. Falsification of any patient record or other clinic documents.
7. Failure to attend any assigned shift or activity (this is inclusive of all clinic rotations, field events, marketing activities, meetings or scheduled patient visits).

8. Missing a scheduled patient or failure to be present at the time of a scheduled patient visit.
9. Violating HIPAA.
10. Any action or behavior, determined by a Clinician or the Health Center Administration to be unprofessional, exhibited toward a peer, patient, Clinician or member of the Health Center Administration.
11. Failure to handle Medicare patients appropriately, as outlined in Medicare Section of this Handbook.

### Disciplinary actions pursuant to Health Center violations

Violation of Health Center policies or procedures will result in disciplinary action ranging from a verbal warning to suspension with loss of hours and/or credits up to and including referral to the professional committee. The determination of all disciplinary action will be made by Health Center Administration and reviewed by the Vice-President of Academic Affairs within two days of occurrence.

## Health Center Academic Requirements

Health Center practicums are designated courses and Interns will receive a grade based upon performance. Interns should refer to course syllabi for specific information and course requirements. CCE (Council on Chiropractic Education) requires that students maintain full-time enrollment in the last calendar year of training (Trimester 8-10) which includes the Health Center practicum courses.

### Proficiency Exams

The proficiency exam I, administered at the beginning of trimester seven Student Clinic experience, consists of clinical encounters with simulated patients. The cases are straight forward or present a moderate complexity and measure clinical reasoning and competence. This exam will also be utilized to identify deficiencies in the pre-clinical curriculum.

Interns who demonstrate weaknesses on the Clinic proficiency exam I will continue with the student clinic experience where they will be closely monitored and coached by the student health center clinicians. They will be re-tested at the end of the trimester to ensure they have acquired the minimal competency level necessary to function in the outpatient clinics. Failure to demonstrate acceptable competency with this second exam will prevent students from progressing to outpatient clinic. They will remain in the student health center for a continued mentoring program and follow-up testing.

Clinical skills practice sessions will be conducted at the beginning of trimester 7 to reinforce the clinical aspect of patient examination procedures.

The proficiency exam II, administered at the end of trimester nine Outpatient Clinic experience, consists of clinical encounters with simulated patients. The cases present a moderate to high level of complexity and measure clinical reasoning and competence.

Interns who demonstrate weaknesses on the Clinic proficiency exam II will continue with their Outpatient Clinic experience where they will be closely monitored and coached by their clinicians. They will also have regular sessions in the Assessment center to address the specific deficiencies identified during the exam. They will not be able to participate in a Preceptorship or CBI experience until they demonstrate acceptable levels of clinical competency. Failure to demonstrate acceptable competency by the end of trimester 10 will prevent students from graduating. They will remain in the Logan clinic system for a continued mentoring program and follow-up testing.

## Competency Modules

Concurrent with completion of trimester 8 and 9 clinic requirements, interns will participate in a variety of Competency Modules designed to enhance the clinical experience. These modules are stand alone courses, but because of their relevance to patient care are being mentioned in this Handbook.

During trimester 8 clinic, interns will participate in the following Competency Modules listed as courses with designated credit hours.

Module I – Clinical Laboratory Interpretation I – During this module interns will review, interpret, and provide a plan of care based on a history, exam findings, and a series of clinical labs. These are submitted to the assigned clinician for review and grading.

Module II – Radiology Conferences—This course extends the imaging concepts and diagnostic value through attendance at Radiology Conferences conducted by the Radiology Department and Residents.

Module III –Radiology Positioning – A review course of radiographic patient positioning for the axial and appendicular skeleton with components conducted in both the Outpatient Clinics and Radiology Positioning Labs.

Module IV – Case Report – This course is designed to provide interns with the skills necessary to write and present a clinical case in a format appropriate for consulting with other professionals as well as developing a case report for publication in a peer-reviewed journal.

Module VI – Marketing –This module reinforces the student's use of the communication skills necessary for patient procurement.

During Trimester 9 clinic, interns will participate in the following Competency Module.

Module V – Clinical Laboratory Interpretation II – This module is conducted the same as Module I.

## Graduation Requirements

| | |
|---|---|
| Physical Examinations/Clinical Exams (up to 5 may from SHC*) | 15 (5 students) |
| Outpatient Adjustments** (50 within Student Clinic and a combination of paying general public (TYPE I) and community service/public relations (TYPE II) patients) | 250 (minimum of 100 TYPE I patients from fee for service clinics) |
| New Patients | 10 |

| | |
|---|---|
| Area X-ray studies (15 phantoms) | 30 |
| X-ray impressions | 30 |
| Physiologic Therapeutics | 35 |
| Urinalysis | 25 |
| Complete Blood Counts | 20 |
| Blood Chemistries | 10 |
| Narrative Reports | 2 |
| Rectal Examinations | 10 |
| History on different patients that must be assessed | (required by trimester) |
| Examination on different patients that must be assessed | (required by trimester) |
| Diagnosis on different patients that must be assessed | (required by trimester) |
| Adjustments that must be assessed by direct observation | (required by trimester) |
| Pelvic/Gynecological Examinations | 10 |

* *A maximum of 5 physical examinations may be performed on students or student family patients.*

*** A minimum of 200 outpatient adjustments must be accrued to be eligible for graduation. Of these, no more than 100 adjustments from community service/public relations (TYPE II) patients can be applied to the minimum requirement. Student family status is defined as a Logan student's parent, spouse or children (includes son-in-law and daughter-in-law). Siblings and other relatives are considered to be general public patients. ALL 10 new patient and all 200 of the adjusting credits required for graduation MUST come from the intern's assigned clinic, which include assignments at community service clinics.*

Trimester 7-10 Health Center requirements are outlined in the appropriate syllabi for each practicum course.

## NEW PATIENT CREDIT REQUIREMENTS

As a graduation requirement, the intern must work up 10 new patients. These new patients can not include student family members. New Patient credit will not be granted for alumni.

This information is recorded by Health Center personnel. New Patient credit is given by the Clinician by electronically forwarding the New Patient Credit Form to the records department. Each item listed on the New Patient Credit Form needs to be accomplished before the Intern receives the new patient credit. The Intern's attending Clinician initials each item as the Intern completes this checklist. This form is then recorded by Health Center personnel. A maximum of four (4) CM10 credits can be obtained from community service (TYPE II) patients.

### Criteria for New Patient Credit

1. For new patient credit purposes, a new patient is defined as one who has not been seen in the Logan Clinic system for a period of one year.

2. The intern will complete a consultation and history.

3. The intern will complete an examination.

4. The intern will integrate the history and examination findings into a diagnosis and treatment plan appropriate to the patient's presentation.

5. The intern will deliver a report of findings.

6. The intern will provide an adjustment, or other treatment, if indicated.

7. The intern will complete appropriate record keeping requirements. This includes follow-up documentation of non-compliance or other reason for not following recommendations as well as issuing a discharge letter, which must be scanned into the file.

8. The new patient welcome letter will be sent to the patient and a copy is to be scanned into the file.

## Laboratory Interpretations

Interns are required by Logan Health Center policy to interpret CBC, UA, and blood chemistries. Interns evaluate and record results of lab specimens and return these to the Clinical Rotation instructor for review. Credit is awarded for accurate interpretations. Those interpretations that are not acceptable are returned to the Intern for further research and/or clarification. Laboratory credit can be earned from:

- Laboratory results from course #CL05705-02
- Analyzing laboratory specimens from an Intern's patient file (Trimester 7).
- Completion of laboratory interpretations and treatment plans through Competency Modules I and V.

### How to Write a Laboratory Impression Report

1. Interns must list slides and/or case number used for their evaluations.
2. List abnormal or borderline results. Arrows can be used to indicate increased and decreased values.
3. Develop a differential diagnosis.
4. Develop a working diagnosis.
5. List additional testing needed to verify your diagnosis or differentiate between other diseases. Additional testing includes laboratory, radiology, etc.
6. Provide a plan of care or follow up strategy based upon the correct working diagnosis

## Radiology Impressions

### How to Write a Radiographic Impression Report

1. When viewing films for writing an interpretation, it is best to look at all the films at one time.

2. Scan all the films noting abnormalities. Go back to these areas only when all films have been looked at.
3. Postural films are an integral part of our radiology study at Logan. Begin the body of your report discussing postural problems such as convexities, shifts in weight bearing, pelvic un-leveling, and alignment.
4. Note any congenital deformities or anomalies such as spina bifida, transitional segments, tropism, etc.
5. Note any suggestion of pathology. Note the size, shape, location, and characteristics of the lesion. If possible, offer a differential diagnosis. (It is rare for a radiologist to offer a definitive diagnosis.)
6. After looking at the skeleton, visualize the soft tissues.

State overall impression. This serves to summarize and condense the material, focusing on the most significant findings. These findings should be numbered with the most important finding listed first, progressing to the least important.

## Radiology

Graduation requirements include the accumulation of 30 technology credits. Credits are given by the Radiology Department when the Intern assists or takes films on a patient.

For every patient receiving imaging services ordered through Logan Health Centers, the treating intern will present the case to the radiology department. The presentation will include the history, pertinent exam findings, the intern's x-ray impression and differential diagnosis.

## Outside Internship Programs

CHIPs

There are three opportunities for trimester 8 interns to work with a licensed Doctor of Chiropractic on Tuesdays from 1-5pm at the CHIPS Health and Wellness Center (www.chipsstl.org). The Intern would remains in their assigned clinic for two of their three shifts. This may not be available each trimester as the intent is to allow interns to stay additional trimesters to ensure continuity for the patients.

The selection of the interns will be made by the chiropractic director at CHIPs. Applications will be made available on Self-Service as openings arise. This internship runs from the 7th week of trimester 8 through the 6th week of trimester 10.

Scott Air Force Base

There are four opportunities for trimester 9 (two) and 10 (two) students to work with a licensed Doctor of Chiropractic at Scott Air Force Base. This is a full time internship position. Applications will be available on Self-Service and are due the 7th week of the trimester 8 term. The selection will be made by SAFB personnel. Federal government vaccination requirements may apply.

Veterans Administration Medical Center

There are opportunities for up to nine trimester 10 students to work with a licensed Doctor of Chiropractic at the VA Medical Center. This position is for one day per week and the intern would remain at their assigned clinic for the other two of their three days. Applications will be available on Self-Service and are due the 7th week. Interns will be selected by VA personnel. Federal government vaccination requirements may apply.

BioFreeze

Trimesters 9 and 10 students will be able to apply for an internship in the BioFreeze program. The selection for the program will be made by the BioFreeze staff. The intern selection requirements and selection criteria will be the same as for a private CBI clinic and are listed below. Applications are made during trimesters 8 and 9 and due by the end of the 7th week.

Paraquad

Trimesters 9 and 10 students will be eligible for internships at Paraquad. Preference will be given to Masters students studying rehabilitation. Selection will be made by the Paraquad staff.

## Trimester 10 Preceptorship Program

The objective of the Trimester 10 Preceptorship Program is to supplement the clinical education of the Intern with practical experience in a private practice environment. The Preceptorship Program allows qualified Interns to work outside of the Logan Health Center System such as in a private practitioner's office during their last Trimester at Logan. Interns may work under the auspices of any practitioner who has met the guidelines and requirements set forth by Logan. A list of accepted preceptor doctors is available from the Health Center Secretary. If an Intern chooses to preceptor with a doctor who has not been pre-qualified, the Intern may request that the Health Center staff mail a preceptor doctor application to this practitioner. It is suggested that the Intern initiate this process at the beginning of Trimester 9.

In states where Interns can participate in patient care as determined by state statute, the maximum duration of the preceptorship is eight (8) weeks. In states not allowing direct patient care by Interns, the maximum duration of the preceptorship is six (6) weeks.

Hours worked during a preceptorship are applied to course #0963-Trimester 10 Outpatient Health Center Practicum. The minimum length of any one preceptorship is two weeks. Regardless of the extent of involvement in a preceptorship, Interns are responsible to work for a total of 15 weeks in clinical activity. Interns may preceptor with no more than two field practitioners with a minimum of two weeks, 40 hours, with any one practitioner.

Intern Eligibility Health Center administration reserves the right to modify the requirements based on changes in state and institutional requirements.

1. Successful completion of all coursework through Trimester 10 and completion of ALL clinic requirements with the exception of hours for HCP VI. Preceptorship cannot begin until the 7th week (state dependant) of Trimester 10.
2. Completion of academic requirements of Trimester 10, including senior research project.
3. Intern must be in good academic and professional standing.
4. Intern must pay all debts and fees prior to leaving.
5. Intern must go through the entire check out process for both the Health Center and the Bursar's office.
6. Successful completion of all graduation requirements with the exception of hours in Trimester 10 clinic (Course #HC10907_01)
7. Intern must submit a completed application to the Clinical Business Systems Director.
8. Selection of students is subject to evaluation of professionalism, ethics, and attitude.
9. Interns are not eligible to preceptor with an immediate family member, such as a parent (or step-parent), grandparent, sibling, aunts, uncles or in-laws.
10. Transfer of patients seen at a Logan Health Center via their assigned Clinician. (Interns are not allowed to see Logan patients in a preceptor doctor's office.)
11. Interns must accept responsibility for previous commitments as they relate to patient care.

Once you have signed out on preceptorship, hours to be applied to Trimester 10 course requirements can be obtained through the Preceptorship Program only. Should you need to return for Board reviews, etc. you will be expected to use available vacation time. If there is a problem with your preceptorship experience and you must return to a Logan clinical setting, it is your responsibility to make arrangements prior to your return. You will be assigned a minimum of 25 hours per week in various types of clinical rotations.

### Guidelines for Intern Involvement

State statutes mandate the level of Intern involvement and supersede all other guidelines for Intern involvement.

1. An Intern on a preceptorship may be able to participate in providing services such as taking X-rays, report writing, performing patient physical exams, providing physical therapy and, depending on state laws, providing chiropractic treatment.
2. Interns are required to work closely with a preceptor doctor who allows them to get involved with performing consultations, patient examination, delivering report of findings, analyzing X-rays, patient education, and records/documentation.
3. Interns are encouraged to work with preceptor doctors who will involve them in office management procedures such as billing, insurance, report writing, etc.
4. Interns must work within the confines of state law.

5. Senior check-out requirements must be fulfilled. Interns will return to Logan to handle all senior check-out responsibilities and participate in all graduation activities.
6. No more than one student Intern may preceptor in any one doctor's office at any time.

### Preceptor Doctor Selection and Responsibility

1. The preceptor doctor must employ standards of patient care comparable to those employed in the Logan Health Centers and as taught by Logan University, College of Chiropractic.
2. The preceptor doctor must be licensed and in good standing with the Board of Chiropractic Examiners in the state where the preceptor doctor resides and practices.
3. The preceptor doctor must be of high moral character and maintain a good professional reputation in his/her community and amongst peers.
4. The preceptor doctor must have a minimum of five (5) years practice experience.
5. The preceptor doctor must submit a copy of his/her current malpractice insurance policy summary sheet with current dates and limits of coverage. Minimum liability limits are $1,000,000/$3,000,000
6. The preceptor doctor must agree to comply with any regulations regarding preceptorship which pertain to his/her state of practice.
7. The preceptor doctor must submit a copy of their current license with expiration date.
8. The preceptor doctor must submit a copy of their business card on their letterhead stationery, a copy of a sanitized file, as well as a current resume or Curriculum Vitae.
9. The preceptor doctor must average a minimum of 80 patient visits per week in the preceptorship office. The preceptor doctor must average a minimum of three new patients per week.
10. The preceptor doctor must have graduated from an institution that is accredited by a chiropractic accrediting agency that is recognized by the U.S. Department of Education (USDE) and the Council on Post-Secondary Accreditation (COPA).
11. In the event that Logan receives negative information concerning a preceptor doctor and/or the business conduct of the preceptor doctor's office, Logan will re-evaluate the preceptor doctor's eligibility to continue in the program. The decision of Logan is final.
12. Field practitioners interested in becoming an approved preceptor doctor must fill out an application packet that can be obtained from the Clinical Business Systems Director. The Health Center Secretary will notify field practitioners of their acceptance via written correspondence once all paperwork and verification of good standing have been received. The College of Chiropractic shall have the absolute discretion to accept or reject any application. A field doctor who applies to the preceptor program agrees to be bound by the decision of the committee. A preceptor manual is available to all doctors and students involved in this program.

Preceptor Doctor Responsibilities include but are not limited to:

1. Providing a practice environment that permits the Logan Intern to experience the chiropractic principles and practice as taught by Logan.
2. Supervising the Intern's activity and providing educational feedback.
3. Verifying hours worked by an Intern.
4. Being present in person at all times when an Intern is their office or working out of the office.
5. Evaluating the Intern's performance and submitting evaluations to the Clinical Business Systems Director by required deadlines.
6. Maintaining current information with the Clinical Business Systems Director.

The Clinical Business Systems Director monitors all preceptorships and provides central organization of all correspondence, Intern assignment and evaluations. The continued good professional standing of all preceptor doctors will be verified in writing on a Trimester basis via correspondence with individual state boards. The director periodically contacts a preceptor doctor to verify Intern involvement and performance. This contact may be through written correspondence, surveys, and checklists as well as on site visits. Interns are asked to evaluate their preceptor doctor at the conclusion of their preceptorship.

### Interns Not On Preceptorship

All assigned shifts and clinical responsibilities at the Intern's primary clinic are mandatory. In addition to these shifts, other clinic duties are available to interested Interns (i.e. additional duties at St. Patrick's Center, ARC, CHIPs, Paraquad, SAFB, VA, etc.). Other duties may be assigned as outlined in the Trimester 10 syllabus, through the Health Center Administration.

## General Procedures and Information

### Paging Codes

301 – Intern's new patient has arrived and is filling out paperwork

302 – New patient has completed their paperwork

300 – CLINICIAN only….new patient is ready

400 – CLINICIAN only …. please come to the front desk.

102 – Intern's patient has arrived and signed in

103 – Complimentary evaluation/spinal screening

200 – Intern has a message, please check carousel

205 – Intern has a message regarding a patient

111 – Intern roll call, report to Health Center front desk to check in

204 – CLINICIAN only…phone call

## Patient Records/Files

The patient health records are all stored and maintained in the Electronic Medical Record (EMR). HIPAA compliance requires that the patient records may only be viewed and worked on while in the walls of the respective clinic. Patient files are not to be printed and removed from the clinic. Failure to keep the patient file secured constitutes a potential breach of HIPAA and patient confidentiality.

The file should contain the following external documents (scanned into the Electronic Medical Record):

1. Copy of Driver's License
2. Copy of Insurance Card
3. Financial Disclosure Form
4. Consent forms:
   - Informed Consent,
   - Consent to Examine,
   - Consent to Treat and
   - Consent to Diagnostic Ultrasound and/or Imaging
5. Patient Information Sheet
6. Any and all correspondence from the insurance company
7. Lab reports, X-Ray reports, outside medical records
8. New Patient Letter
9. HIPAA Notice

There are **NO** paper files. Any correspondence with the patient or about the patient **MUST** be scanned into the EMR and filed in the appropriate area either for storage or shredding.

## Patient Records

Logan's HIPAA policy states that **NO** patient file(s), documents or record(s) may be removed from any Health Center. The reception desks at Logan's satellite clinics will maintain all hard copies of documents scanned into the EMR and discard or place into storage as defined by procedures and appropriate. *(A copy of this policy is in the back of this handbook for Intern signature and confirmation.)*

## Documentation and Record Keeping

The patient file is a permanent legal document that may be called as evidence in a court of law. Records **MUST** be accurately maintained within the EMR system. All external documents such as radiology reports and outside patient information must be scanned into the EMR by

front desk staff.

- Copies of records are often sent to insurance companies, attorneys, worker's compensation offices, and Medicare (U.S. Government).
- All radiology reports and outside patient information must be scanned into the file.
- All entries are required to be completed the day of the patient visit, and electronically signed by the attending Clinician. Any changes the Clinician requires of the record must also be signed electronically.

### Obtaining Informed Consent

The components of informed consent consist of the patient having knowledge of the nature of treatment, the inherent risks involved in that treatment, alternative treatments that are available and the risks if the condition is left untreated. A patients' agreement to undergo examination, diagnostic testing, and treatment recommended by the doctor after the securing of this information from the doctor is an indispensable legal requirement. The process of informed consent requires the doctor to discuss all of its elements with the patient and answer any questions that the patient may have regarding the examination and treatment discussed. Only after this has been accomplished may the doctor proceed with care. This not only applies to the different forms of treatment, but also is necessary when obtaining diagnostic tests to identify the presence or absence of disease.

The explanation of the nature of care or procedure to be performed provides practical advantages along with satisfying legal requirements. A patient that has a reasonable understanding of a procedure is less likely to be surprised or startled by the delivery of that procedure and is more likely to be cooperative and relaxed during the delivery.

Discussion of the risks of treatment should include those risks that are material and inherent. There is no obligation placed on the doctor to identify risks that are not inherent (foreseeable, natural, related) to the procedure or are not material (sufficiently likely and significant) to the procedure.

Initially, informed consent should be obtained prior to performing diagnostic testing or treatment of a condition. There is not necessarily a need to repeat the process unless the treatment is new or altered or a not previously discussed diagnostic test is being performed.

It is required to have the patient sign an informed consent document that is scanned into the patient's file. This is a legal requirement in some states. It is also necessary to document in the daily care note prior to providing care that informed consent has been obtained.

- The initial consent that is given is consent to the chiropractic examination.
- After complete history, examination and report of findings the Intern shall obtain the consent to chiropractic treatment. This will outline any and all treatments that will be performed on the patient. Along with the treatment it gives detail on all inherent risks involved.

- If the intern decides to get x-rays or other diagnostic test like Doppler Ultrasound consent must be obtained. This consent will help the patient understand any and all risks involved with the procedures.

Once consent has been obtained and signed by the patient and a witness, the form will be scanned into the patient electronic medical record.

## Patient's Rights

Logan College of Chiropractic/University Programs respects the unique differences of our patient, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from his/her Clinician and/or senior Intern relevant, current, and understandable information concerning diagnosis, treatment and prognosis.
- The patient has the right to know the identity of their Clinician, senior Intern and all office staff involved in their care.
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
- The patient has the right to every consideration of privacy.
- The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
- The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the Clinician and/or senior Intern of available and realistic patient care options.
- The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution.
- Each patient is urged to fill out and return a patient satisfaction form.

## Dissatisfied Patient

All employees of Logan Health Centers share responsibility for providing prompt and courteous service to all patients. This service includes, but is not limited to, full explanation of the Financial Disclosure Form and answering all non-clinical questions from patients. On occasion, dissatisfied patients may voice their concerns and wish to have these concerns addressed. In the event your patient indicates dissatisfaction, please have them contact the Clinical Business Systems Director or Director of Clinical Care.

## Problem Oriented Clinical Record Keeping System

The Problem Oriented Clinical Record Keeping System was developed by Lawrence L. Weed, M.D. This system aids the Clinician/Intern in the methodic, organized and scientific delivery of health care. The components of the system are:

1. The Data Base – which includes the patient's health history, social history, family history, OPPQRST, the chief complaint, examinations, laboratory and radiology information;
2. Problem List; including the ICD-9 codes for each problem
3. Initial Plans, including assessment; and
4. Discharge Summary

The doctor obtains information from the patient concerning his or her complaints through the use of consultation and health history. In this manner the doctor questions the patient about present complaints in addition to obtaining information concerning additional health problems both past and present. The Intern is to ascertain pertinent information concerning the chief complaint using the OPPQRST system. The exams are performed and information recorded in the EHR.

Within the HER program is a section called medical/chiropractic alerts. The Intern is to list serious problems with a patient in this area so that this information is highly visible to the treating Intern and Clinician. Examples include back surgery, stroke history, cancer survivor, RA, prolonged steroid history, congestive heart failure, etc. This is a very important form to fill out completely and accurately.

## Initial Plan/Patient Care Plan

This form records the patient's diagnosis, radiology series ordered, and describes the type of care and frequency of care needed to get the patient well. In order to build a proper note in the EMR you will first come up with a problem list. This problem list utilizes ICD-9 codes, but this list is different than your diagnosis. The problem list is very generic; it will use codes like neck pain, headaches, shoulder pain, low back pain, knee pain, etc. During the course of the consultation and physical examination you will narrow down the problems to more specific diagnoses codes.

The consultation and physical exam is solely documented electronically. On the first encounter with the patient the intern will state to "build" the patients EMR. The entire patient visit will be captured in the EMR; this will include patient's family and self history, height, weight, past medical history, medication: past and present, diet, smoking history, past surgeries, etc. By the end of the first visit the intern will have a well rounded understanding of the healthcare condition that the patient is in.

Before the Intern begins treating a patients, they must have a Patient Care Plan (previously called a treatment plan) signed off on by the supervising clinician. The PCP covers date of initial visit, diagnosis, length of treatment, services to be performed, re-exam date, wellness recommendation(s), etc. This form will allow the supervising clinician to have a "snap shot" of the overall plan with the patient. The PCP will be populated upon initial workup and updated at the first re-exam and every re-exam thereafter. Missouri State law required there always be a current treatment plan that is being abided by. Failure to do so will result in NO credit for that patient and could ultimately put the patient in danger.

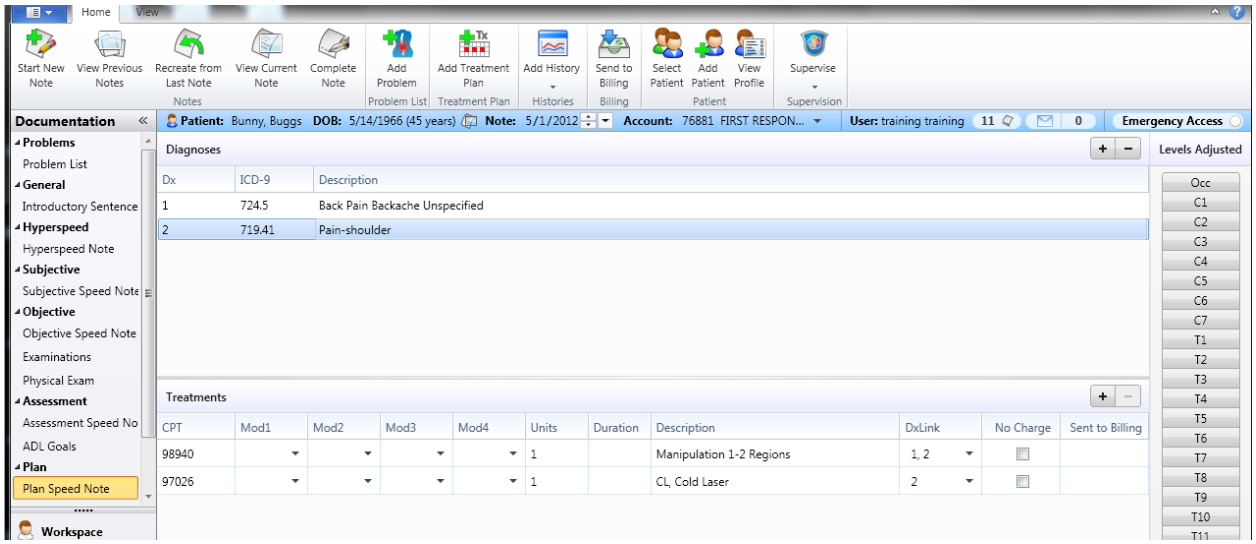
Each visit must have a SOAP note documented within the EMR. A new note should be started during the first visit (physical exam, new patient visit), visit number 2 and any re-evaluation visit thereafter. Accurately document what the patient reports and pertinent exam findings on follow-up visits. The problem list might not change, the diagnosis may be the same, but you must change what the patient told you at the beginning of the visit along with their clinical findings.

If a patient cancels or reschedules their appointment, this must be documented. To document this you will start a new note and under "Introductory Sentence" you will type exactly what was discussed with the patient on the phone or if the patient did not show, that is what you would type. There will not be an actual SOAP note for this encounter, but the intern and clinician will still need to sign off on the note.

The intern must complete all SOAP notes by the end of business the same day that treatment is rendered. By the end of the patient encounter the intern must have filled out the Plan Speed Note in the EMR and the CPT codes should be sent to billing. This will ensure that the travel sheet and the SOAP note match and the patient will be able to check out in a timely manner. Below is the process that should be followed:

INTERNS:

- Log onto eConnect
- Check "APPS" (under Workspace): ensure all are "ON"
- Treat Patient
- Complete "Plan Speed Note"
- Review codes for modifiers, reduced services, no charge, etc.
- Click: Send to Billing button at top of page
    - If Send to Billing is grayed out: check – Account – if None – use drop and pull in account; if none is the only option, go to the front desk and have account information completed.

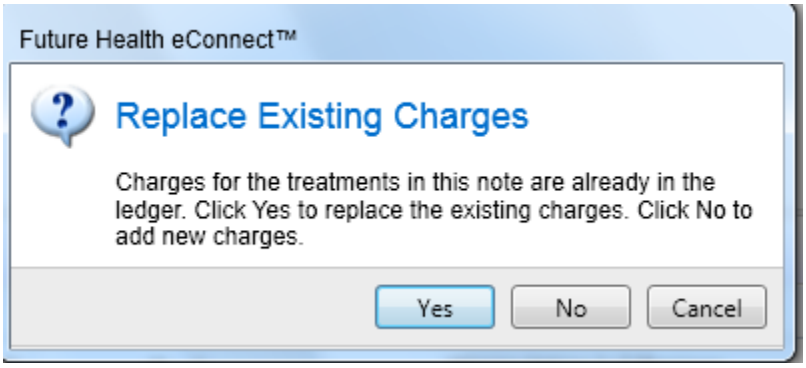



- If NO changes to the "Plan Speed Note"

- Clinician signs off on the travel sheet.
- Patient is ready to check out

➢ If changes ARE made to the "Plan Speed Note":

- The clinician makes the necessary changes and clicks: SEND TO BILLING
- The following box appears. Click: YES




Charges will replace what was originally sent to billing.

- Clinician signs travel sheet
- Patient is ready to check out.

NOTES:

- ❖ All "No Charge" – interns do not receive credit.
- ❖ Clinicians have 72 hours to complete all notes. After 72 hours charges are released and sent to carriers.

The treatment plan is approved by the Clinician and cannot be altered without the consent of the Clinician. This form also records future plans for examination, radiology, etc. The treatment plan is to be updated as the patient progresses through care and should reflect all changes in care. If the Intern begins to treat the patient for a new diagnosis or releases the patient from care, this is noted as well. A Report of Findings is given to the patient on the second visit and this report is reflective of the treatment plan. Any change in the treatment plan should not be discussed with the patient until the Intern has approval of the attending Clinician.

## Progress Notes

Interns are to utilize the SOAP format to fully and accurately record patient information. SOAP notes allow the doctor to record and document any impressions regarding the clinical progress of the patient and any changes from the original therapeutic plan. Every patient visit is documented even if no treatment is rendered. Missed or cancelled appointments should be recorded in the file. Phone calls along with the purpose and content of the dialogue with or pertaining to the patient also need to be recorded in the file. It is important to question the patient thoroughly regarding their response to care. The Intern is expected to inquire with specific questions to ascertain in what ways the patient has improved, lack of improvement or negative changes in the patient's status. For example, the patient tells the Intern he feels 'fine'. The Intern is expected to question the patient to ascertain what 'fine' means.

Interns are expected to re-examine their patients every 3-8 visits to document progress or lack of progress. This documentation gives the Intern and Clinician data to assess the status of the patient, but also documents the need for additional care for insurance purposes.

All progress notes must be signed (electronic signature) by the Clinician observing and directing care. The SOAP note **must** be completed the same day the case was given. The SOAP notes must be approved and signed electronically by the Clinician the same day as the case was given. **Failure to complete** this will result in "**no-credit**" given for the treatment.

## SOAP Notes

When using the SOAP format, the following are keys to remember what patient information belongs under each heading:

- "S" what the patient says on their own and responses to questions from Intern
- "O" what the Intern finds on examination and observation
- "A" diagnosis and overall response to care (i.e. improving, stable, etc.)
- "P" what services/treatment and suggestions the Intern renders to the patient that day and future plans. This includes home advice, nutritional supplements purchased by the patient, referrals to other practitioners, etc.

Following is a more detailed description of the SOAP format:

"S"—The patient's SUBJECTIVE complaints are noted. The chief complaint and OPPQRST are recorded here. Any pertinent patient history should be recorded here as well. The Intern can note in the SOAP to see the history and consultation form for more information.

For existing patients, Interns record the patient's current status in their words as well the patient's response to the Interns questions. Interns should inquire into the patient's type of relief, degree of relief, how long the relief lasted, activities since last treatment, sleeping difficulties, etc. This line of inquiry establishes if the current treatment plan is working for the patient. These simple questions validate the need for care. Patient compliance and completion of home instructions should be noted here.

"O"—The OBJECTIVE palpation and positive examination findings are noted here. Negative exam findings should be recorded as well to document that the exams were performed. EN (essentially negative) and WNL (within normal limits) should NOT be used as this terminology provides little useful information and may vary according to different populations. Visual observations by the Intern are noted here (i.e. gait, posture, skin coloring, etc.).

During all follow-up visits, the following information should be noted: ROM of any area of the spine to be adjusted, the muscle tone, areas of redness, discoloration, swelling, and tenderness. Areas of tenderness can include muscles, capsules, spinous processes, ligaments, and interspinous spaces, etc. Interns should remember that to record a 'spasm', frank loss of motion should be noted in the area of

complaint. A true spasm is noted in antalgic postures. Hypertonicity of a muscle can be noted as (^tone) with or without tenderness. Subluxation levels to be adjusted are noted here, which is required for Medicare eligible patients.

All new complaints, injuries should be examined and findings recorded here. For example, the Intern has been treating a patient for a low back problem for three weeks, and one day the patient tells the Intern they have a headache or were in a minor fender bender the night before. The new complaint warrants a full work up. IMPORTANT: no area of the spine can be adjusted without an adequate examination, history, and if needed, radiology.

Radiology and laboratory findings are recorded in this section as well. For example, the Intern orders a CBC for a patient. The results were negative except for an elevated WBC. The Intern would record in the file, 'CBC results from 7/9/12 received, all counts and morphology unremarkable except elevated WBC of 11,000. Further, the Intern records in the file that this information was explained to the patient.

"A"—The ASSESSMENT section of SOAP notes should contain a minimum of two items: the diagnosis, including the ICD-9 code AND response to care or the status of the patient. A diagnosis may have multiple components included within its substance. It should list the tissue/anatomy of origin of the complaint (muscle, tendon, ligament, joint, bone, viscera, etc.) and/or the mechanism of injury to that tissue. It should include any complicating or co-morbid conditions that will affect the tissue response (spasm, osteoarthritis, diabetes, degenerative disc disease, etc.). Finally, the listing of the chiropractic diagnosis of subluxation or segmental dysfunction should follow. An example would be cervical strain with myofascitis superimposed upon degenerative disc disease with subluxation at C5/6. The above scenario would be for a symptomatic patient.

A statement regarding the patient's response to care should be included. Typically, the patient should be improving under care, however, in some cases, the care may be supportive or maintenance. In these cases, the patient may not progress, but the condition may remain stable under care. Occasionally, patients may get worse if the condition is not responsive to care or if the diagnosis has not been clearly identified. In this case, the note should reflect that the patient's condition has deteriorated or declined. This may also be the case when a patient has been placed on reduced ADLs, but has not complied with the care plan. This situation requires that the failure of compliance be listed in the Subjective component to identify the reason for the patient's decline.

It is essential to remember that the diagnosis should always reconcile the subjective complaint *and* the objective findings or any variance from what may be expected. If the patient is demonstrating inadequate progress, this will provide evidence for additional investigation and testing to determine the cause for said variance in the progress of the patient.

"P"—The PLAN is written to record the specific treatment rendered and the Intern's future plans for care for the patient. If it necessary to refer the patient for consultation with another provider, this is noted in the "P" section of the progress note. When recording this information include the following:

1. Adjusting treatment: The type of adjustment given including patient positioning (prone or side posture) and the type of move utilized (rotary, P-A, lateral flexion, etc.) Record if the patient tolerated the procedure well or if not tolerated. PTPW can be written down which represents 'patient tolerated procedure well.'
2. Nutritional Advice and Sales: Name supplements recommended or sold to patient, the dosage advised, frequency and any specific instructions. Dietary advice should be recorded.
3. Exercises: The file should contain pictures of the specific exercises given to the patient along with frequency and number of repetitions. If the Intern demonstrates the exercises, this should be recorded as well.
4. Therapy provided: The type, location, settings, and **duration** of passive modalities must be listed. Active care performed must also be listed as to the type, repetitions, etc. Example, 'interferential at 80-120 Hz for 20 minutes with sweep applied to lower lumbar spine.' If cryotherapy is utilized and a damp towel is placed between the patient and the ice pack, record as a 'covered ice pack'. **It is imperative that the length of treatment, including the clock time for all physical therapy modalities and/or rehabilitation procedures be included in the note.**
5. Home Instructions: Intern records advice given to their patient. Example: 'patient instructed to avoid lifting over 10 pounds for 1 week and to ice lumbar area for 15 minutes every hour for the first 2 days.' 'Vitamin C recommended for one month, 2,000mg total per day, 500mg with each meal'.
6. Ordering of diagnostic studies: These should also be included in this section of the visit note and identify what is being ordered and the purpose for ordering the study. Example, "ordered a CBC and thyroid panel to evaluate cause of patient's fatigue."

**Medicare documentation has some very specific requirements and these items are listed in the Medicare section of this Handbook.**

## Developing a Patient Care Plan

After the proper diagnostic work-up of a new patient or a current patient's new problem comes the development of a treatment plan. A planned, thoughtful approach to addressing the patient's needs can make the difference between success and failure. All treatment plans must be approved by the attending Clinician before any treatment can be started.

Treatment plans are based on what needs to be done in order to achieve both the short and long-term goals. This will vary depending on the condition's severity, chronicity, complexity, and complicating factors such as the patient's age, occupation, other problems, etc. It is not based on either potential scheduling conflicts or method of payment.

Goals include short term ones, usually symptom reduction, and long term, usually stabilizing the patient biomechanically to prevent recurrence.

Development of a treatment plan should include consideration of the following options: What you will pick will depend on the patient, but the basic considerations should include:

- Adjusting;
- Physiotherapy; passive and active
- Rehabilitation - Stretching and exercise;
- Dietary changes/nutritional supplementation;
- Ergonomic changes;
- Orthopedic support;
- Work and activity restrictions; and
- Additional diagnostic testing strategies

It is also necessary to determine the frequency and duration for each selected component.

### Treatment Frequency

The frequency of care depends primarily on the duration and severity of the condition. Some patients may need to come in daily. Most patients start out at three times a week, a few at twice a week. As the condition becomes less acute, the frequency of treatment should decrease and the patient should assume increasing responsibility for their own care.

Two basic levels of care should be considered: Active, and Preventive/Maintenance care.

**Active care** is considered to be that care that is delivered to return the patient to pre-clinical status after an illness or injury. It is further broken into the following categories:

- Relief care is directed towards symptom reduction and functional restoration to a tolerable level.
- Therapeutic care is directed towards further symptom reduction and functional improvement such that the patient can accomplish normal ADLs with little exacerbation.
- Rehabilitative care is directed toward improvement of function to pre-clinical status. The restoration of strength and flexibility is accomplished through additional patient education and therapy.
- Supportive care is necessary when the injury or illness has caused a permanent unstable condition that prevents the patient from returning to pre-clinical status. In these cases, treatment is directed toward support of the unstable condition along with follow up and treatment to reduce the frequency and intensity of anticipated exacerbations.

**Preventive/maintenance care** is care of the asymptomatic patient or patient that has reached pre-clinical status with the condition being resolved or stable. Preventive care with periodic examinations for early detection of problems allow for cost effective strategies in managing a patient's health. Early detection of illness or disease will help to prevent development of a more serious condition, thus reducing overall costs for health.

There are three categories of conditions treated under active care: acute, sub-acute, and chronic.

- Acute—condition or illness with a sharp, severe and relatively short course and is usually a new condition.
- Sub-acute—typically used to describe a condition between acute and chronic, but the condition will have some acute features.
- Chronic—a long-standing, recurrent condition of greater than 1 year in duration.

These are further broken into descriptors of the magnitude of the condition using the terms mild, moderate, and severe. Under the acute and chronic conditions, these descriptors assist in determining what level of care may be required to achieve the most favorable outcome.

In the acute condition, these descriptors indicate the levels of care:

- Mild—uncomplicated condition that requires relief and occasionally therapeutic care. Does not require rehabilitative or supportive care.
- Moderate—these conditions will require relief and therapeutic. Commonly, these also require rehabilitative care, but not supportive care.
- Severe—as a result of the complicated nature of these conditions, these require all four levels of care to obtain maximum medical improvement. Pre-clinical status may not be achievable in this circumstance.

Chronic conditions may require a different level of care based upon the long standing nature of the complaint as well as the potential unstable nature of the condition.

In the chronic condition, these descriptors indicate the levels of care:

- Mild—in the absence of acute exacerbation, this may require little relief care, but will necessitate therapeutic, rehabilitative and supportive care.
- Moderate—with acute exacerbation, this may require all four levels of care.
- Severe—in the presence of acute exacerbation, this may require extended periods of all four levels of care.

Tables for management of acute and chronic conditions as published in *The Chiropractic Manual*, available through the Ohio State Chiropractic Association, are listed on the following pages. These will assist the Intern in developing an appropriate frequency and duration of care based on the preceding information. The following are merely guidelines to be considered and are not intended to be required levels of care:

## Guidelines for Management of Acute Conditions

| Type of Condition | Levels of Care | Frequency of Care | Duration of Care |
|---|---|---|---|
| Mild | Relief | Daily to 3 visits/week | 1 – 15 days |
| | Therapeutic | 3 visits to 1 visit/week | 0 – 30 days |
| | Rehabilitative | None | None |
| | Supportive | None | None |
| Moderate | Relief | Daily to 3 visits/week | 7 – 21 days |
| | Therapeutic | 3 visits/week to 1 visit/week | 30 – 60 days |
| | Rehabilitative | 1 visit/week to 2 visits/month | 30 – 60 days |
| | Supportive | 2 visits/month to 1 visit/month | 0 – 3 months |
| Severe | Relief | Daily to 3 visits/ week | 21 – 45 days |
| | Therapeutic | 3 visits/week to 1 visit/week | 30 – 90 days |
| | Rehabilitative | 1 visit/week to 2 visits/month | 45 – 90 days |
| | Supportive | 2 visits/month to 1 visit/month | 3 – 5 months |

## Guidelines for Management of Chronic Conditions

| Type of Condition | Levels of Care | Frequency of Care | Duration of Care |
|---|---|---|---|
| Mild | Relief | None | None |
| | Therapeutic | 3 visits/week to 2 visits/week | 14 – 45 days |
| | Rehabilitative | 2 visits/week to 2 visits/month | 45 – 90 days |
| | Supportive | 2 visits/month to 1 visit/month | 3 – 6 months |
| Moderate | Relief | Daily visits to 3 visits/week | 14 – 45 days |
| | Therapeutic | 3 visits/week to 2 visits/month | 45 – 90 days |
| | Rehabilitative | 2 visits/week to 2 visits/month | 90 – 180 days |
| | Supportive | 2 visits/ month to 1 visit/month | 6 – 12 months |
| Severe | Relief | Daily visits to 3 visits/week | 30 – 60 days |
| | Therapeutic | 3 visits/week to 2 visits/month | 60 – 120 days |
| | Rehabilitative | 2 visits/week to 2 visits/month | 90 – 180 days |
| | Supportive | 2 visits/month to 1 visit/3 months | 6 – 18 months |

### Duration

The duration of a care plan may vary and depends on a variety of factors, including; chronicity, severity, complicating health factors (including those related to the patient's age), exacerbating circumstances, patient compliance, and response to treatment. Some conditions will never resolve, such as osteoarthritis. Others, such as a mild uncomplicated sprain, usually resolve quickly. Typical treatment plans, however, run 6-9 visits, at which time a full re-evaluation will be performed to determine what level of care will be necessary for the next sequence of care. Wellness, maintenance and preventative care plans are drawn after the maximum improvement in the patient's condition has been reached.

## Wellness/Follow-Up Care

Treatment plans are generally written around a patient condition. Wellness, preventative and maintenance care plans vary. While there are no universal definitions, you can think of them this way: wellness care is for patients who have realized the benefits of chiropractic as an all around means of staying healthy. Wellness concepts should be presented to all patients at the Health Centers. This should include an assessment of the patient's weight, sleeping habits, nutritional consumption, physical exercise, and social habits such as smoking. It's the responsibility of the Chiropractic Physician to analyze and discuss with his/her patient's wellness. Clinical Laboratory studies may be necessary to perform. Preventative care is for patients who have had a condition in the past and are trying to prevent a recurrence. Maintenance care is for patients who have a permanent or chronically- recurring condition and would like to minimize and stop its progression.

## Discharge Summary

A patient may be released from care when a problem has resolved, because of a lack of continued progress, or lack of progress entirely. This is to be noted in the SOAP notes and verified by regular examinations. Referral to other health professionals is noted here. For those patients who reach resolution, the Intern is to educate the patient on the merit of wellness care and modify the treatment plan to reflect this. The Intern is to notify the front desk that a patient has been discharged as well as write DISCHARGE on the patients last travel sheet. The front desk and financial office need this for billing and insurance purposes. This notification is extremely important for patients under care for injuries related to an MVA, PI, or worker's compensation claim.

## Narrative Reports

Interns are required to write 2 narratives on new patients or reactivated patients. Clinicians must sign the narrative and send a copy to data processing to be recorded. The narrative must be professionally written, thorough and accurate.

The narrative report is a multi-purpose patient presentation format that is utilized in reporting to physicians, insurance companies, and the legal profession. A properly written narrative can eliminate the need for copying records and often answers the frequently asked questions regarding a patient's current and past health status. It is a convenient summary of diagnostic testing, the patient's treatment and response to care as well as the prognosis.

A narrative report should include the following items:

1. An introduction to the patient which outlines the patient's age, complaint type and duration of complaint;
2. History of the present illness (HPI). This is followed by the OPPQRST which details the chief complaint;
3. Past health conditions/ surgical history/medical/chiropractic history (PMHx)/Social Hx.;
4. Review of systems;
5. Physical and regional examination findings;
6. Laboratory/x-ray/advanced imaging results;
7. Diagnosis and concurrent conditions or complicating factors;
8. Treatment that was rendered, including type, frequency, and duration;
9. Home instructions, such as dietary and exercise instructions; and
10. Response to care and prognosis.

This format contains the basics and can be modified. However, it is important that all components be present to adequately and completely describe the patient's condition. As with all health information, the narrative report should be considered part of the patient's legal record and confidentiality should be maintained.

## Insurance

Logan Clinicians are providers for Blue Cross/Blue Shield and Healthlink. Your patients should consult with the front desk staff to discuss all billing, insurance filing and reimbursement matters. Interns should not intervene on their patient's behalf in these matters and should only be concerned with providing the patient with the care they need.

Logan College will file insurance for patients, however, the patient pays for services rendered at the time of their visit. Exceptions are made for participating managed care contracts, and only the co-payment will be collected.

Patients involved in a car accident or worker's compensation claim must fill out additional paperwork. If the patient reports either of these circumstances, it is the Intern's responsibility to notify the attending Clinician. The Clinician will facilitate the necessary actions to handle these cases (i.e. obtain additional paperwork, contact financial office, collect appropriate insurance information, etc.) If the patient has been a regular patient at a Logan Health Center, and is involved in an MVA, the front desk staff will need the information to switch from billing their medical insurance company and begin billing the automobile insurance company.

## Worker's Compensation

In the State of Missouri, the employer must verify and approve benefits in order for Logan to collect payment from the insurance carrier. If the employer does not consent for the patient to be treated at Logan, the patient will have to pay for services rendered.

It is important that the front desk staff verify the claim and receive verbal approval for Logan to treat the employee/patient. It is also important that the patient understand the situation prior to the start of care.

To prevent Conflicts of Interest, employees of Logan Univeersity that are injured on the job will not be treated in the Logan Health Center System.

## Personal Injury

Because of the inherent litigious nature of personal injury cases, and the fact that they often come to trial years after the injury, it is the policy of Logan that these circumstances be thoroughly explained to the patient. Logan will not carry these accounts pending a liability settlement. If patients with personal injury claims would like to be treated in the Logan Health Centers, they will have to use their personal insurance and/or personally stay current with their bill.

## Medicare

Medicare will only reimburse the patient if the Clinician (a licensed D.C.) adjusts the primary area of subluxation. Clinicians sign paperwork for each Medicare patient stating that they adjusted the patient. This is critical for insurance purposes.

The Intern must document in the SOAP notes that the Clinician adjusted that area and have the notes signed by the Clinician. The Clinician that adjusts the patient must sign the travel slip, SOAP notes and the form that is submitted with the insurance claim stating that the licensed D.C. treated the patient on that date. If any of these are left unsigned, no credit will be awarded.

Interns must utilize the PART documentation system for all Medicare patients. All components must be present to demonstrate that the patient was in need of the care and deems the visit eligible for payment by Medicare. Missing any component of this documentation system could result in denial of payment to Logan or reimbursement to the patient.

The components of PART documentation are described below. **For the note to meet the documentation standard, it must include at least two of the four components and at least one of either A or R.**

**P – Pain and tenderness –** identify using one or more of the following

- Percussion or Palpation asking the patient if the procedure is causing them discomfort or pain
- Visual Analog Scale rating the pain 0-10
- Numeric Rating Scale asking the patient to verbally rate the pain 0-10
- Pain Questionnaire

**A – Asymmetry/Misalignment –** identified on a sectional or segmental level

- Observing patient posture or gait analysis
- Palpation – static or dynamic describing the vertebral misalignment and asymmetry

**R – Range of motion abnormality -**

- Observing an increase or decrease in the range of motion
- ROM measuring devices like goniometers or inclinometers
- Motion palpation, including the listings or directional change.

**T – Tissue Tone changes**

- Observation of swelling, inflammation, rigidity
- Palpated tissue changes like hyper or hypotonicity, tautness, etc.
- Use of instrumentation documenting the instrument used and findings

Interns who inappropriately handle Medicare patients by not involving the Clinician in the patient's care will be subject to the following penalty: A) first offense, no credit will be given to the intern for that adjustment. B) Second offense, no credit will be given to the intern for that adjustment AND the intern will be suspended for one (1) week. C) Third offense, no credit will be given to the intern for that adjustment, the intern will be suspended for two weeks AND the intern will lose the eligibility to treat any Medicare patients.

Federal law dictates that providers must file insurance for Medicare patients, therefore, Medicare patients do not file their own insurance.

## Release of Records

The release of a Logan patient's records to another physician, insurance company or to the patient themselves is handled by the patient records staff. Additionally:

Patients must sign the release form before the patient records can be released. The release will be placed in the patient's file.

- To maintain patient confidentiality, Interns must NOT discuss patient information with anyone other than the patient themselves or with the parent of a minor.
- Patients receiving x-rays on digital x-ray equipment will be provided with a DVD of their exam.
- Records received from other doctors/hospitals will be given to the Clinician. The Clinician then reviews the information with the Intern.
- Requests for patient records from other doctors should be handled the records department.

## Physical Therapeutics (Modalities) and Rehabilitation

The use of therapeutic modalities is essential to hasten a patient's recovery from acute complaints and rehabilitation is used to restore appropriate tissue integrity along with preventing future injury. The following information is appropriate to the use of these therapeutic procedures.

1. Utilization of modalities in the treatment room must be pre-approved by the Clinician supervising the patient.

2. Modalities must be administered according to the treatment plan which has been approved by the Clinician. No changes can be made unless approved by the Clinician treating the patient.
3. Interns are expected to report any adverse reactions experienced by the patient to the assigned Clinician.
4. Interns are expected to return equipment back to the appropriate area as soon as they are finished. Interns need to return the equipment cleaned, with electrical cords untangled, and replace hydrocollator pads to the tanks, etc.
5. All equipment defects, damage, missing parts, etc. are to be reported to the Clinician.
6. Theft of Logan property will result in dismissal and will be reported to the local authorities.

### Treating a Minor/Child

Patients under the age of 18 must have a parent or legal guardian present during the patient visit. The parent or legal guardian must sign an informed consent allowing the child to be examined and treated. Any changes in the plan of treatment of a minor patient must be approved by a parent or legal guardian. Failure to obtain this consent can have significant medical/legal consequences and the Intern will be subject to disciplinary action.

## Protocol for Treating Patients

### Patient Scheduling

Patient appointments should be made 24 hours in advance. In the case of emergencies, 30 minutes prior notice is required. Emergencies will be determined at the discretion of the attending Clinician.

Patient appointments are scheduled by the front desk PSRs. When a patient calls the clinic to make an appointment, the PSR will check the intern's rotation schedule, room availability, and schedule the patient during one of the intern's assigned shifts. Interns are strongly encouraged to discuss scheduling with the patient during the Report of Findings and make every effort to schedule the patient for all visits during that phase of care immediately after the ROF. By doing this, the intern, patient, and clinic staff are assured that the room is available and that there will be no intern/patient/room schedule conflicts. This will also reduce the need to repeatedly attempt to coordinate schedules between patient, intern, and treatment rooms. Should a patient call to schedule an appointment and not be available on any of the intern's assigned days, the PSR will inform the patient that the appointment can be made, however, the intern may not be available at that time. If this occurs, another intern will be assigned to provide care for that visit.

Travel sheets must indicate the date of the patient's next appointment or a "will call" if the patient is unable to schedule an appointment. It is best to get the patients to schedule as they can always cancel their appointment if a date is inconvenient. Please arrange follow-up appointments in the treatment room and not at the check-out counter.

Interns will not receive credit if they by-pass the front desk admitting and patient check out procedures.

Interns may only treat patients at their assigned Health Center. Patients are assigned to Clinicians and can only be seen at that Clinician's site. The Clinic front desk will list names of all new patients seen at each Health Center and provide to each clinician:

- Patients name
- Assigned Intern
- Shift A or B

This will provide the clinician with a visual reminder of necessary follow-up and responsibility. Unscheduled patients will be informed that since their Intern did not make an appointment, they will be worked into the schedule as soon as possible, but they may have to wait until a room is available. Clinicians may withhold credit from an Intern treating unscheduled patients.

There will be occasions when a scheduled patient does not arrive for the appointment. The patient should be called as soon as possible after the scheduled appointment time to reschedule the appointment. The dialogue with the patient in that conversation should be noted in the file. If the Intern is not able to reach the patient, or if a message is left with someone or on an answering machine regarding the missed appointment, it should be documented in the file. **All chart entries must be signed (electronic signature) by a Clinician.**

## Assignment of Patients to Interns

Whenever possible patients will be distributed equally among the Interns assigned to a given location.

- Established patients:
    - Trimester 10 Interns will meet with the Clinician(s) prior to leaving the Health Center System to participate in a preceptorship or to graduate. The Clinician(s) will assign new Interns for each patient, distributing them between the Trimester 9 and Trimester 8 Interns.

- "Walk-in" patients:
    - A "walk-in" patient is a patient who either does not have an assigned Intern, or, comes into the Health Center for treatment at a time when their assigned Intern is not present. The Clinician will assign an Intern on shift to care for "walk-in" patients. The front desk staff will keep a rotation list of Interns on shift at any given time. Two separate rotations will be tracked – "walk-in" adjustments, and "walk-in" new patients. The "walk-ins" will be assigned to the next Intern on the list. After an Intern receives the opportunity for a "walk-in" the next Intern on the list will be given the next opportunity. If an Intern misses an opportunity due to absence, other patient appointments, failure to bring appropriate equipment, declining the opportunity, or any other reason, he/she is skipped. He/she will not receive another opportunity until the shift list cycles back to his/her name. A rotation list will exist for each clinician/intern group and the walk-ins will be assigned by alternating from Clinician to Clinician.

- If, at the discretion of the Clinician, an Intern is skipped due to technique requirements, the Intern skipped will receive the very next opportunity for a "walk-in".

## New Patient Procedures

A new patient is defined as any person not previously evaluated at any Logan Health Center or an existing patient who has not been evaluated or treated in the prior 12 months. (See the New Patient Flow Chart.) Logan Health Centers provide the patient with a comprehensive evaluation, and therefore, Interns should allow 1 to 1-1/2 hours for the first visit. This should be explained to the patient by the Intern and the front desk personnel.

The last new patient schedule time is 5:00 p.m., Monday through Thursday, 4:00 p.m. on Fridays and 10:00am on Saturdays. This allows adequate time to process new patients before clinic closure.

The Consultation is done by the intern under the direction and supervision of the Clinician. The level of participation by the Clinician in actually conducting the consultation is determined by his/her comfort with the intern's skills in conducting a consultation. Typically, there is more Clinician involvement with newer interns until the Clinician is satisfied that the intern has the knowledge and skills to collect the necessary information.

When the consultation is complete and the information has been reviewed by the Clinician, the Clinician or Group Leader will explain to the patient the examination format that is appropriate for the patient (i.e. a regional exam of the area of chief complaint, physical examination and necessary radiology and laboratory procedures). Patients should be informed of the costs of the recommended procedures. Questions regarding payment or insurance matters should be handled by the financial office.

After the examination has been completed, the Intern must consult with the Clinician and review the findings from the exam. The Clinician may chose to double-check the Intern's examination findings as well as explain to the patient the need for x-rays, lab work, and/or referral.

If the Clinician determines x-rays are needed, Interns will be asked to complete a Radiology Information Sheet which is then signed by the Clinician. Female patients must sign an additional form stating they are not pregnant. The Radiology Department that serves all the Logan Health Centers, adheres to the 10-day rule.

The Intern escorts the patient to radiology. Once the films are obtained, a preliminary interpretation of the films will be provided.

The ordering of laboratory studies and x-rays are for the purpose of diagnosis. This responsibility falls onto the Clinician and requires a written order for performance. The order must include the patient name, diagnostic test to be performed, date of the order and signature of the Clinician ordering the study. These orders are done on a duplicate sheet. The person performing the study will initial the order at the time the procedure is performed. The lab/x-ray department will keep the original for their files. The duplicate copy will be entered into the patient file to provide evidence that the study was performed. When the results are obtained, they will be forwarded to the ordering Clinician for review and entry into the patient file.

As previously mentioned, the treating intern will present to case to the radiology department.

The supervising clinician will review the results with the Intern and determination will be made at the time whether to review with the patient at the current or next visit or call the patient for discussion of the results if the patient has already departed.

If it is determined that a phone call to the patient regarding abnormal lab or x-ray findings is necessary, the Clinician ordering the study, not the Intern, should contact the patient. If the result is of a nature that requires referral to another health care provider, the Clinician will inform the patient of this with the Intern present during the consultation. If the result indicates additional testing to determine a diagnosis, the Clinician will discuss this with the patient and arrange for the testing to be performed. These conversations must also be recorded in the patient chart and should include the date, time and content of the conversation.

The Clinician and Intern will formulate a working diagnosis and a treatment plan at this time based upon the consultation and examination findings. Interns are encouraged to provide input and ask questions during all aspects of patient care, however, the Clinician will make the final decisions regarding patient care.

On the second visit, the Intern and Clinician will present the report of findings, the recommended treatment plan, discuss benefits/risks/alternatives and obtain Informed Consent for Care, and answer any questions the patient may have. Once again, questions regarding payment or insurance should be directed to the financial office. Once the patient gives consent for treatment, the Intern evaluates the patient, reviews the findings with the Clinician, has the patient complete the appropriate Outcomes Assessment instrument and care is delivered. The Clinician observes and directs, as necessary, the adjusting procedures. At the conclusion of the treatment, the patient is provided instructions for home care and any questions are answered. The patient is escorted to the front desk, appointments booked, fees paid and the patient departs.

The travel sheet must be accurately marked and thoroughly completed. The travel sheet is given to the Patient Services Representative (PSR) who then can collect payment, give the patient a receipt, and schedule the patient for their next visit.

## Clinical Activity Credits

Interns receive credits based on the information noted on the Travel Sheet. To receive credit you must:

1. Indicate ALL services performed;
2. Include your name, ID number, Trimester level, and assigned Clinician. Please print. Illegible writing will result in no credit;
3. Obtain the treating Clinician's signature;
4. Indicate the date of the next appointment or mark "will call" (must be initialed by the Clinician);
5. Escort the patient to the front desk and give the travel sheet to the check out person;

6. Only one person may receive credit for adjusting a patient; and
7. **No credit will be given if Travel Sheets are turned in late or if any of the above is excluded.** This must be completed by the Intern on the day the service is provided to the patient.

Due to Medicare guidelines, the Clinician must adjust the primary subluxation for patients on Medicare. The primary subluxation is the segment that relates to the chief complaint and is reported to Medicare on the CMS form. Interns may adjust any other subluxations. Additional information is noted in the Medicare section.

## Office Visits—Established Patients

When the patient presents for care, the clinician will be paged. An intern should present to the front desk, greet the patient, obtain a gown, and the Travel Sheet. (Your Clinician may require you to sign out a room for the patient, especially if you need a specialized table. If required, reserve the room ASAP, and make sure it is available prior to bringing your patient back.) Interns are not to wait at the front desk for the patient to arrive.

The clinician should consult with the new intern prior to the intern being introduced to the patient. The intern is expected to review the patient chart and discuss the patient's care with the clinician prior to taking the patient into a treatment room.

Once the patient is ready, begin assessing the subjective portion of your progress notes and obtain objective data including vital signs. At this time, place the green flag outward which notifies the Clinician you are ready to present examination findings and begin adjusting. The Clinician must observe patient adjusting. When a Clinician enters a treatment room, the red flag is placed outward which identifies the location of the Clinician. When the Clinician leaves the room, the red and green flag are pushed against the wall. The Intern now instructs the patient to get dressed and to open the door when finished dressing. The Intern brings the travel sheet and patient to the checkout clerk at the front desk. At this time, the future appointment is confirmed, payment is rendered and the patient receives a receipt. It is the Intern's responsibility to ensure that the travel sheet is accurately and completely filled out. The Senior Intern assigned to the Intern's shift should review and consult with the intern to ensure accuracy of the travel sheet information.

Please refer to the Established Patient flowchart located on page 73 of this handbook.

## Referral from Outpatient Clinic to outside practitioners

Whenever a patient requires referral to another doctor, for whatever reason, the intern will write a narrative report indicating the history, examination findings, diagnosis, or differential, and reason for the referral. This report is to be co signed by the supervising clinician and sent to the doctor. A copy is to be scanned into the patient's file. Templates for this report are available on Self-Service.

## Referral from Student Clinic to Outpatient Clinic/Bio Freeze Center

Patients who are eligible for care by the Student Health Center include: Logan University students, family of Logan University students (spouse, children, parents), and students enrolled in the ASP, Undergraduate, and Masters Programs. There are occasions when these patients may warrant additional care provided by the outpatient clinic on campus, Montgomery Health Center. The procedure for this referral is outlined as follows:

1. Evaluation of the patient must be completed by a Student Health Center Clinician.
2. A Student Health Center Clinician makes a recommendation and a treatment plan is developed.
3. The Student Health Center Director provides a signed written referral that includes a recommendation for the specific type and duration of care.
4. A copy of the referral form is placed in the patient file, and a copy given to the referring Clinician in Student Health Center.
5. The patient file will be transferred from the Student Health Center to Montgomery Health Center. The patient file remains at Montgomery until the plan of care has been completed. The patient is referred back to Student Clinic.

NOTE: Referral will only be made for cases that would benefit from a specialized technique.

Family members of a Logan students may be treated in the one of the multiple Health Centers at the regular out-patient charge (see patient billing classification). The 8th, 9th or 10th Trimester Intern may take care of student family members, but Logan Policy stipulates that the Intern cannot receive outpatient adjustment credit for treating members of their own family.

## Regular Patient with a New Complaint

When treating a patient on a regular basis for a particular problem or wellness care and they patient presents with a new complaint, the clinician will require the Intern to perform a new work up for the new complaint. The Intern must consult with their assigned Clinician regarding this new complaint (before any treatment is rendered), perform a problem focused history, do an appropriate examination, discuss the findings with the Clinician, determine the diagnosis, give a report of findings to the patient, and render the care as decided in the new treatment plan. As with a new patient, a new treatment plan must be completed, and approved by the Clinician. If the patient has been involved in a work-related injury or motor vehicle accident, the financial office will need to have the new insurance information for billing purposes. The patient needs to fill out additional paperwork as well.

## Re-Activated Patients

A re-activated patient is any patient who has not been seen at any Logan Health Center in the past 12 months. The Intern should follow the protocol for evaluating a new patient. Begin by consulting with the Clinician regarding the approach to the patient. The intern may receive new patient credit for this type of a patient evaluation.

## Transfer of Patient Care from One Intern to Another

All transfers of patient care from one Intern to another must be initiated by the Clinician responsible for the care of that patient. Patient transfers occur between Interns within the facility and any exception to this is at the Clinician's discretion. All transfers not following the above protocol will be deemed invalid and the Clinician in charge will assign the patient to an Intern.

## Protocol for School Physicals

Logan Chiropractic Health Centers provide school/athletic/camp physicals to any student from kindergarten through high school at a $15.00 cost. Any additional services such as laboratory will be charged at regular clinic prices. Interns can use the school physical form provided by Logan if a student does not bring a school sanctioned form with them. Reminder to all Interns if you are treating a minor the parent or legal guardian is required to give written consent.

Please follow the following protocol:

1. Clinician and intern greet the student and parent/legal guardian at the front desk.
2. The front desk staff will give you the following:
    a. a consent form signed by the parent or legal guardian;
    b. the physical exam form;
    c. a spinal postural analysis form; and
    d. a Travel Sheet.
3. In the case of physical examinations on minors, the parent ***must*** be invited to be present in the room during the performance of the examination.
4. Clinician and Intern consult briefly prior to beginning the examination.
5. Inguinal hernia examination procedures in females presenting for physicals, including school or athletic physicals:
    **a. This is not a routine examination or necessary to perform on females for sports participation.**
    b. Decisions on whether or not to perform the examination should be made based on the history.

c. If there is a history of a mass or complaint of discomfort in the area, consider the possibility of an inguinal hernia.

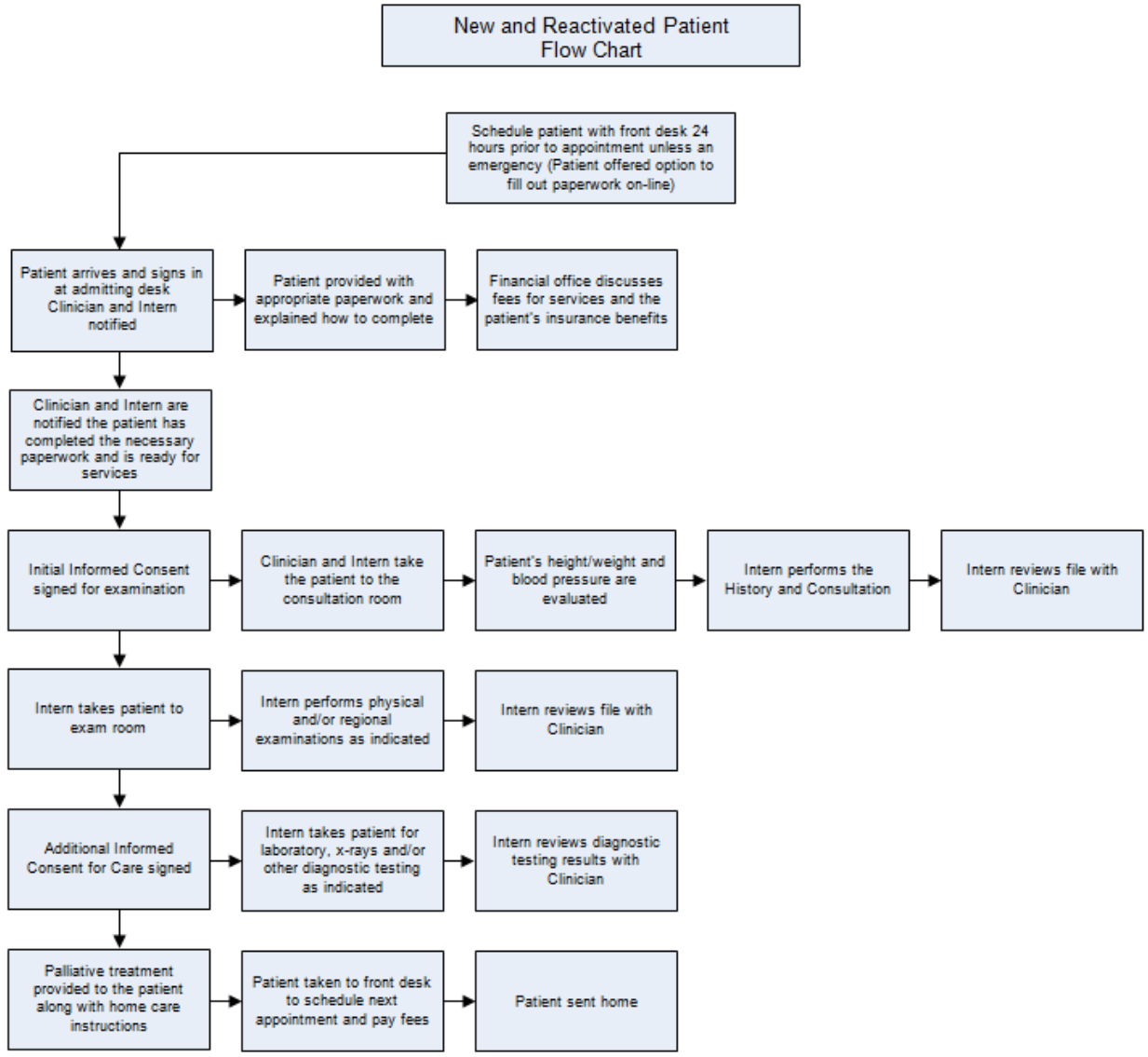
d. If this is a consideration, direct Clinician interaction with the Intern and/or patient is required.

e. The Clinician should speak with the patient and, in the case of a minor, speak with the parent regarding this examination or referral to the patient's PCP for evaluation.

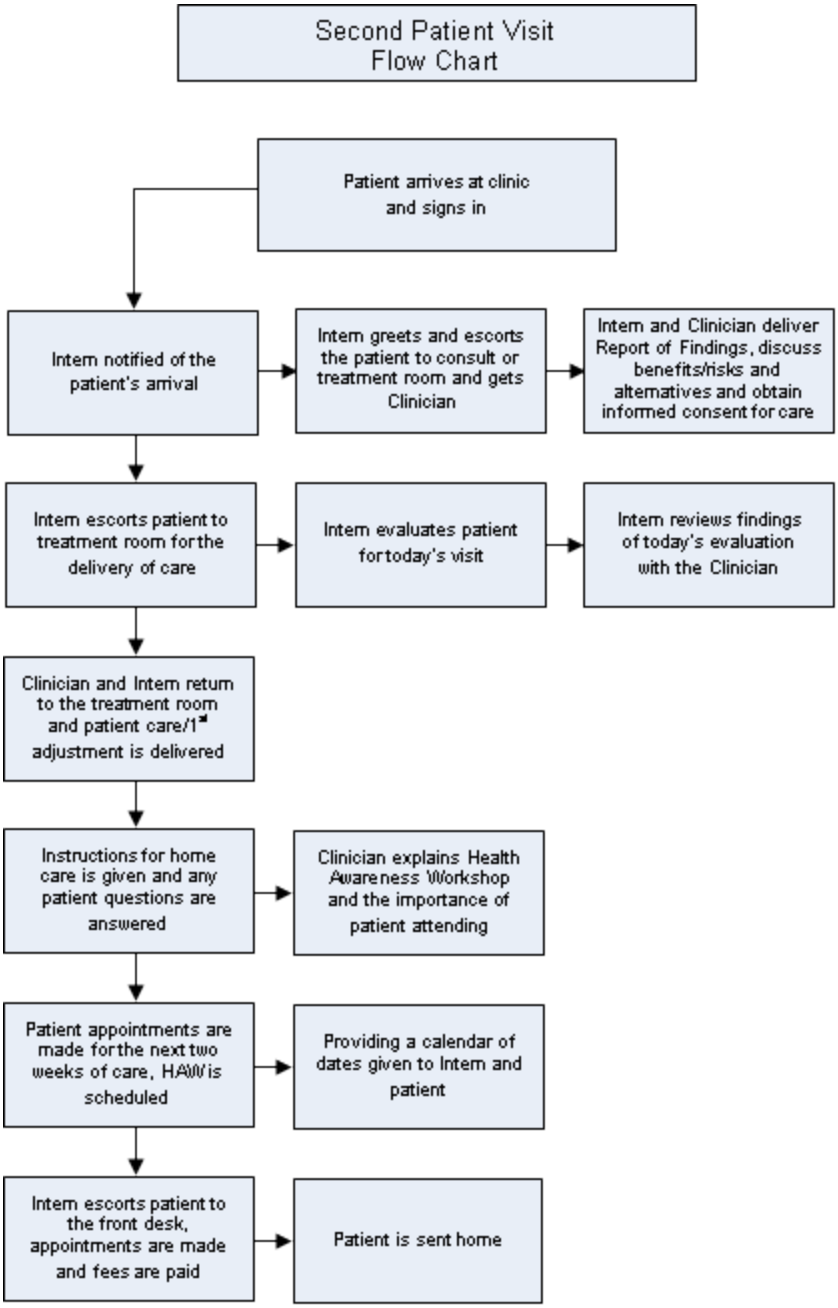
f. If it is decided that a hernia examination is to be performed, the Clinician *must* be present during the exam. If the Intern is a male, a female chaperone *must* also be present along with the Clinician during the performance of the exam.

6. Intern escorts student to treatment room and begins the physical exam. (Interns are encouraged to have another Intern present who is the same gender as the patient.)
7. Intern fills out the physical exam and spinal analysis form.
8. Intern report's findings to the Clinician. The Clinician will double check all pertinent findings and then sign the physical form.
9. If present, the Intern brings parent back into treatment room. The Clinician discusses findings with parent.
10. Intern escorts parent and child to the checkout clerk along with the Travel Sheet.
11. A copy of the exam is given to the patient/guardian and then scanned into the patient's EMR.

# New and Re-Activated Patient Flow Chart



## Second Patient Visit Flow Chart



# Logan's Family Educational Rights and Privacy Act (FERPA) Policy

*Overview*

The Family Educational Rights and Privacy Act of 1974 (FERPA), 20 U.S.C. §1232g, as amended, is a federal law giving certain rights to parents or students regarding education records at schools of every level receiving funding from the U.S. Department of Education. At the postsecondary school level, the rights afforded by FERPA belong, in general, to the student rather than the parent. The five rights, as summarized in the Department of Education regulations, 34 CFR §99.7, are as follows:

- The right to inspect and review the student's education records.
- The right to request the amendment of the student's education records that the student believes to be inaccurate, misleading, or otherwise in violation of the student's privacy rights.
- The right to consent to disclose personally identifiable information contained in the student's education records, except to the extent that FERPA and the regulations authorize disclosure without consent.
- The right to file with the U.S. Department of Education a complaint concerning alleged failures by the institution to comply with the requirements and regulations of FERPA.
- The right to obtain a copy of the institution's student record policy.

1. Right to Inspect and Review. Students may inspect and review their education records upon request to the appropriate record custodian. (See list of types, locations, and custodians of student records at the end of this policy.) The regulations define "education records" as meaning, subject to the few exceptions, those records that are (1) directly related to a student, and (2) maintained by an educational institution or by a party acting for the institution.

A student should submit to the record custodian a written request, which identifies, as precisely as possible, the record or records he/she wishes to inspect. The office of the record custodian will make the needed arrangements for access as promptly as possible and notify the student of the time and place where the records may be inspected. Access must be given within a reasonable time, but in no event more than 45 days from the receipt of the request. When a record contains information about more than one student, the student may inspect and review only that part of the record that relates to him/her.

Logan reserves the right to refuse to permit a student to inspect the following records:

- Financial records of the student's parents.
- Confidential letters and statements of recommendation for which the student has waived his/her right of inspection and review.
- Records connected with an application to attend Logan if the application was denied.
- Those records that are excluded from the FERPA definition of education records.

Logan reserves the right to deny copies of transcripts or copies of records (but not access to the records) in any of the following situations:

- the student has an unpaid financial obligation to Logan, or
- the student has failed to comply with disciplinary sanctions.

2. Right to Seek Amendment. If a student believes the education record(s) relating to the student contain information that is inaccurate, misleading, or in violation of the student's privacy rights, he/she may ask Logan to amend the record. The procedures for amendment of records are the following:

- The student should submit to the office of the record custodian a written request for amendment of the record, identifying the part of the record requested to be changed and specifying why it is inaccurate, misleading, or in violation of his/her privacy rights.
- Logan will decide whether to amend the record as requested within a reasonable time after receiving the request.
- If Logan decides not to amend the record as requested, it shall inform the student in writing of its decision and of his/her right to a hearing.
- If the student requests a hearing, Logan shall hold the hearing within a reasonable time after receiving the request. Logan shall give the student reasonable advance notice of the date, time, and place. The hearing may be conducted by an individual without a direct interest in the outcome, including a Logan official. At the hearing, Logan shall give the student a full and fair opportunity to present evidence relevant to the issues.
- Logan shall make its decision in writing within a reasonable period of time after the hearing. The decision will be based solely on the evidence presented at the hearing and will include a summary of the evidence and the reasons for the decision.
- If, as a result of the hearing, Logan decides that the information is inaccurate, misleading, or otherwise in violation of the privacy rights of the student, it will amend the record accordingly and inform the student of the amendment in writing.
- If, as a result of the hearing, Logan decides that the information is not inaccurate, is misleading, or is otherwise in violation of the privacy rights of the student, it will inform the student of the right to place a statement in the record commenting on the contested information and stating why he/she disagrees with Logan's decision.
- If a statement by the student is placed in the record, Logan shall maintain the statement with the contested part of the record for as long as the record is maintained, and disclose the statement whenever it discloses the portion of the record to which the statement relates.

3. Right to Consent to Disclosure. Logan will not disclose personally identifiable information from a student's educational record without the prior written consent of the student, except:

- to comply with a federal grand jury subpoena or any subpoena issued for a law enforcement purpose, in which case the court or other issuing agency orders, for good cause shown, that the existence or contents of the subpoena or any information furnished in response to the subpoena not be disclosed;

- to parents or legal guardians of students under 21 regarding a disciplinary violation involving a Logan rule or policy governing the use or possession of alcohol or a controlled substance; and
- to school officials within Logan who Logan has determined to have a legitimate educational interest in the records.

The definition of a school official includes, but is not necessarily limited to:

- a person employed by Logan in an administrative, supervisory, academic, research, or support staff position;
- a person employed by or under contract to Logan to perform a special task, such as an attorney or auditor;
- a person serving on the Board of Trustees; and
- a student serving on an official committee, such as a disciplinary committee, or assisting another
- school official in performing his/her task.

A school official, in most cases, will have a legitimate educational interest if the official is carrying out the duties or responsibilities of his/her position. A school official has a "legitimate educational interest" if the official is:

- performing a task that is specified in his/her position description or by a contractual agreement;
- performing a task related to a student's education;
- performing a task related to the discipline of a student; or
- providing a service or benefit relating to the student or student's family, such as health care, counseling, maintenance of the safety and security of the campus or students, job placement, or financial aid.

Without prior consent by the student, FERPA authorizes releases of personal information to third parties as follows:

- to certain officials of the U.S. Department of Education, the Comptroller General, and state and local educational authorities in connection with the audit or evaluation of certain state or
- federally supported education programs.
- in connection with a student's request for or receipt of financial aid as necessary to determine the eligibility, amount, or conditions of the financial aid, or to enforce the terms and conditions of the aid.
- institutions from which the student has received or applied to for financial aid.
- as required by state law.
- to organizations conducting certain studies for or on behalf of Logan.
- to accrediting organizations to carry out their functions.
- to parents of an eligible student who claim the student as a dependent for income tax purposes.
- to comply with a judicial order or a lawfully issued subpoena.

- the results of any disciplinary proceeding conducted by Logan against an alleged perpetrator of a crime of violence to the alleged victim of that crime.
- at a time of emergency defined in terms of the following considerations:
    - the seriousness of the threat to health or safety;
    - the need for access to the record in meeting the emergency;
    - whether the person requesting the records is in a position to deal with the emergency; or
    - the extent to which time is of the essence in dealing with the emergency.

In these instances, a record of access will be kept by Logan that indicates (a) the name and signature of person who requested or examined the file; (b) the purpose for which the file was accessed; (c) the date on which access to record occurred; and (d) clear notice that the information must not be released by a third party without the consent of the student. Logan will keep notification of releases made to third parties in the student's record.

Directory Information is information that Logan may disclose but is not required to be disclosed without prior consent by the student.

Logan designates the following as Directory Information: name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received (including Dean's list), and the most recent previous educational agency or institution attended by the student.

In accordance with the requirements of FERPA, Logan annually will give public notice to students in the *Student Handbook, Catalog*, and website of the types of personally identifiable information that Logan has designated as directory information. Furthermore, Logan will give the student the opportunity to refuse to let Logan designate any or all types of information about him or her as directory information. Copies of forms to request non-disclosure of directory information are available in the Registrar's Office.

Record of Requests for Disclosure. Subject to certain expectations set forth in FERPA regulations, the record custodians within Logan will maintain a record of all requests for and/or disclosure of information from a student's educational records. The record will indicate the name of the party making the request, any additional party to whom it may be disclosed, and the legitimate interest the party had in requesting or obtaining the information. The record may be reviewed by the student.

4. Right to File a Complaint. Students have a right to file a complaint with the U.S. Department of Education if they believe that Logan has failed to comply with the requirements of FERPA. The complaint should be in writing and contain specific allegations of fact giving reasonable cause to believe that a violation of FERPA has occurred. The complaint should be sent to:

Family Policy Compliance Office
U.S. Department of Education
Washington, D.C. 20202-4605

5. Types, Location, and Custodians of Student Records All students have records in one or more of the following offices, maintained by the custodian listed.

| Type | Location | Custodian |
|---|---|---|
| Admissions Records | Admissions Office | VP of Enrollment |
| Advising Records | Advisor's Office | Academic Advisor |
| Counseling Records | Counselor's Office | Counselor |
| Credential Files | Registrar's Office | Registrar |
| Academic Records | Registrar's Office | Registrar |
| Disability Records | Student Services | Dean of Student Services |
| Disciplinary Records | Student Services | Dean of Student Services |
| Accounting Records | Business Office | Chief Financial Officer |
| Financial Aid Records | Financial Aid Office | Financial Aid Director |
| Supplemental Seminar and Training Certification | Postgraduate Office | VP of Chiropractic Affairs |

# Appendix A — Acupuncture Policy

Acupuncture services may only be provided by interns who have completed a Logan 100-Hour Acupuncture Certification Course and successfully passed the course examination. There are no exceptions to this requirement. Interns are permitted to provide acupuncture services only under the direction of a Logan clinician who is certified in MTAA through the Missouri State Board of Chiropractic Examiners.

Interns will be required to read and acknowledge by signature that they have read and understand the manual.

Interns will be required to sign out needles before treatment and then dispose of used needles and return unused needles after patient care. The intern will be required to sign out after returning unused needles.

# Appendix B — Logan Confidentiality Policy

The following are general internal business affairs of the Health Center that should be recognized:

1. Health Center business should not be discussed with anyone outside the Logan organization except as may be required in the normal course of business. Information designated as confidential is to be discussed with no one outside the Health Center and only discussed within the Health Center on an "absolutely need to know" basis.
2. All patient care information is highly confidential. Its release, disclosure or discussion with Health Center or non-Health Center personnel or other students or parties in other than required normal and routine business situations is strictly prohibited. Any breach of this information may be grounds for immediate termination of employment.
3. All incoming inquires regarding the internal operations of the Health Center shall be directed to the Chief of Clinical Services or Director of Health Center Support Services.
4. All outgoing media information regarding the Health Center must be approved in advance by the Health Center Administration and sent to the Public Relations Office.
5. All information regarding the employment of any employee shall be referred to the Logan Human Resources Department.

I attest that I _____ have read the above policy and will comply with its contents.

Signature: _____ Date: _____

Violation of this policy will result in disciplinary action including but not limited to:

- Letter of Reprimand
- Probation
- Suspension
- Dismissal
- Possible termination

cc: Personnel file & Student file

# Appendix C – Agreement to Comply With Health Center Rules

The definition of the practice of Chiropractic in the State of Missouri which became official on August 18, 1982 is as follows:

The "practice of chiropractic" is defined as the science and art of examination, diagnosis, adjustment, manipulation and treatment of malpositioned articulations and structures of the body. The adjustment, manipulation or treatment shall be directed toward restoring the normal neuromuscular and musculoskeletal function and health. It shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine. The practice of chiropractic is declared not to be the practice of medicine and operative surgery or osteopathy within the meaning of chapter 334, RSMo, and not subject to the provisions of that chapter.

- As a student Intern at Logan, I agree to practice within the confines of the Laws of the State of Missouri and rules and regulations of Logan College Health Centers including, but not limited to, the following:
- Physiological therapeutics may only be used as an adjunct to a chiropractic adjustment and must be ordered by a Clinician.
- Nutritional supplements may only be used as an adjunct to a chiropractic adjustment and must be approved by a Clinician.
- Acupuncture may only be utilized by the licensed health center clinician who has received certification by the State of Missouri and Logan that he/she has met the requirements for acupuncture use. Acupuncture is to be utilized in designated areas as outlined in this procedural manual.
- No personal advertising or personal business cards shall be permitted.
- Logan Basic Technique and Diversified Technique may be utilized in Trimesters 7-10 in the Health Center practicum. Other techniques such as Applied Kinesiology, SOT (which includes cranial work), Gonstead, Cox, Thompson, Activator, Graston and Active Release Technique all require prior certification of proficiency, previous enrollment in and successful completion of the Specialized Technique classes taught at Logan College (does not include post-graduate courses). In addition, approval of the Chief of Staff is required. Diversified and Basic Technique only may be utilized in Student Health Services.
- Patients may only be treated within the confines of the Logan Health Center proper and only under the direct supervision of a Health Center Clinician who is a licensed Doctor of Chiropractic. This approval for treatment is rendered in writing by the Health Center Clinician. Consulting, history taking, advising, examining, or treatment of patients outside the Health Center will result in disciplinary action and possible dismissal from the College. All services, tests, etc. must be ordered by a Logan Health Center Clinician. Failure to follow this protocol will result in disciplinary action and possible dismissal.
- Patient confidentiality and HIPAA compliance must be maintained at all times.

- All patient records shall be kept current and accurately reflect the treatment method that was utilized, the date of each visit, and any other pertinent information concerning the patient file on the date of the patient visit.
- Unethical or unprofessional conduct relating to patients, faculty, staff, or colleagues are grounds for disciplinary action. Failure to present for patient appointments constitutes unprofessional behavior and will be dealt with.

I understand that the privilege of practicing chiropractic within the clinical internships and related courses is dependent upon the standards of behavior that are separate and in addition to academic performance. The evaluations of these standards are continuous and include, but are not limited to, the following considerations: good emotional and physical health, concern for the welfare of patients; consideration of patient rights; professional demeanor in the Health Center and classrooms. I understand that it is a violation of both Logan Health Center Rules and the standards of professional conduct governing the practice of chiropractic to: a) become socially or intimately involved with a patient under my care; and/or b) to treat patients with whom I have a pre-existing social and/or intimate relationship (see Duties and Responsibilities of Interns). I further understand that it is expected I will be free of any alcohol or drugs when engaging in patient contact. Signs of alcohol or chemical use will result in immediate dismissal from the Health Center and referral for counseling (see the Drug and Alcohol Policy). If, in the opinion of the Director of Clinical Care or his/her designate, unsatisfactory behavior is demonstrated, I may be referred to appropriate evaluations to determine my suitability to continue to practice chiropractic within the Health Center System. Refusal to submit to necessary evaluations, when properly requested to do so, will result in complete loss of Health Center privileges.

I understand that any violation of these rules or other Health Center policies and regulations are grounds for disciplinary action by the Health Center, Institution, and/or the Professional Standing Committee. It is the intent of Logan College to provide chiropractic care to its students and student families at minimal cost. The definition of student family is defined in the clinic handbook. Payment is expected when services are rendered unless arrangements for deferred payment have been made in accordance with Health Center policy. All deferred Health Center charges incurred by student family members will be charged to the student's account. Responsibility for payment rests solely with the student. All outstanding charges must be paid in full at the time of registration/graduation in accordance with school policy.

AGREEMENT: I have read and understand this agreement and the Health Center Handbook and will abide by the guidelines contained herein and in future addendum.

Intern Signature : _____ Date: _____
Print Name: _____

# Appendix D – Policy for the Safeguarding, Movement, and Transportation of Patient Records and Other Media Between Facilities

The purpose of this policy is to ensure that Logan College Clinicians, staff, and students safeguard patient protected health information (PHI) and other confidential information while transporting patient files and records from satellite clinics to the main campus. This policy has been developed in addition to, and is to be read in conjunction with, Logan College's HIPAA Compliance Manual and the Logan College Health Center Handbook.

Logan College policy states that patient files or records may not be removed from a Health Center. However, there are limited circumstances under which transportation of patient files and records may be necessary. Such circumstances include, but are not limited to, facilitation of patient care or treatment, facilitation of patient service/access, and/or administrative purposes.

In circumstances where patient records and/or files must be transported from one facility to another, the Clinician and/or staff member will assign the duty of transporting patient files, records, and other media to an Intern. The assigned Intern is responsible for timely delivery of information between the satellite clinic and the main campus. The following mandatory procedures apply to the transportation of patient files and records:

- The reception desks at Logan's satellite clinics will maintain all patient records, reports, and other information containing PHI in a locked courier case. At Montgomery Health Center, the Radiology Department will maintain PHI in a locked courier case.
- The reception desks at Logan's satellite clinics staff will maintain a "transportation log." The delivery acceptance log will identify the name of the Intern responsible for delivery, the destination clinic, the date and time of pick-up, and a catalog of patient records and reports scheduled for delivery. At Montgomery Health Center, the Radiology Department will maintain the transportation log.
- At the conclusion of his or her shift, the assigned Intern will come to the reception desk and complete and sign the transportation log.
- After the Intern has completed the transportation courier log, the reception desk staff will present the locked courier case to the Intern for delivery to the destination clinic.
- The courier case must never be left unattended.
- The courier case should never be placed in plain sight.
- The assigned Intern must deliver the locked courier case to the destination clinic's drop-off area. An Intern transporting files to the Montgomery Health Center must complete this delivery prior to 9:00 a.m. Monday-Friday.

- The reception desks at Logan's satellite clinics will maintain a "delivery confirmation log." The delivery confirmation log will indicate the Intern responsible for delivery, the date and time of delivery, and the items delivered. At Montgomery Health Center, the Radiology Department will maintain the delivery confirmation log.
- The Intern responsible for delivery will complete and sign the delivery confirmation log.

I have read and reviewed Logan University's Health Center's Policy for the Safeguarding, Movement, and Transportation of Patient Files and Other Media Between Facilities. I understand that it is imperative that I follow the policies and procedures set forth above in order to safeguard the privacy of protected health information. I further understand that violation of this policy will be grounds for immediate disciplinary action.

Signature: _____ Date: _____