

Record Keeping Compliance Checklist

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This checklist is provided to assist Oregon licensees in assuring their compliance with chiropractic health care records regulations. *(It is NOT rule language but meant to serve as a tool or guide)*

Records are:

- clear, legible, complete, and accurate;
- every page of the records identify the clinic of origin by name and address.

Records describe the Case History which includes:

- a description of the chief complaint for which the patient sought treatment from you;
- documentation of any significant event that affects the chief complaint of the patient;
- a record of the patient's health history;
- a record of having obtained informed consent (per oar 811-035-0005);
- a record of the initial and subsequent examinations (including relevant findings such as height, weight, blood pressure, pulse, temperature, respirations, etc. as clinically indicated) and the results;
- a record of the diagnoses.

Patient Management to include:

- a record of the treatment plan for care of the patient, and if there are any changes or modification to the plan, the reasons for those changes;
- a record of where a chiropractic adjustment(s) was performed on the patient;
- a record of the date (month, day, year) on which services were provided to the patient and what services were performed, including the provider of service and author of the record;
- a record of the patient's response to treatment;
- a copy or synopsis of any clinically relevant correspondence or communication with the patient, providers consulted regarding the patient, providers to whom the patient is referred, or other pertinent information regarding the overall clinical picture of the patient.

Financial Information (maintained for at least seven years from last transaction):

- A record of charges for services performed and billed to the patient, an insurance company, or another person or entity who has assumed the financial responsibility for the payment services performed to a patient