Arizona Chiropractic Board of Examiners Workshop Handout

Summary of Key Behaviors, Documentation Standards, and Relevant Arizona Rule & Statute Citations

This handout summarizes major professionalism, boundary, communication, and recordkeeping expectations discussed in the presentation 'Board of Examiners: How to Avoid a Complaint and What to Expect if There Is One.'

Key Professional Behaviors That Reduce Board Complaints

- **Maintain Professional Boundaries:** Avoid flirtation, suggestive humor, comments on appearance, unnecessary touch, emotional dependency relationships, or excessive self-disclosure. Explain touch before contact and use draping and informed consent consistently. *Related Authority: A.R.S. §32-924 (Unprofessional Conduct)*
- **Communicate Professionally:** Avoid overpromising outcomes, fear-based language, anti-medical rhetoric, or financial pressure tactics. Clearly explain risks, expectations, and treatment rationale. *Related Authority: A.R.S. §32-924*
- **Use Social Media Carefully:** Patients may screenshot or share online content. Avoid misleading claims, inappropriate humor, or unprofessional public interactions. *Related Authority: A.R.S. §32-924; FTC Advertising Guidance*
- **Maintain Professional Office Culture:** Train staff regarding professionalism, consent, patient respect, privacy, and appropriate financial practices. Office culture problems frequently contribute to complaints. *Related Authority: HIPAA Standards; A.R.S. §32-924*
- **Respond to Complaints Carefully:** Written responses to Board complaints become part of the permanent investigative file. Poor or emotional responses may worsen a situation. *Authority: A.R.S. §32-929*

Arizona Chiropractic Recordkeeping Expectations

- **Required Record Contents:** Patient records should include health history, examination findings, diagnosis or clinical impression, treatment plans, daily notes, services rendered, billing records, and progress documentation. *Primary Authority: A.A.C. R4-7-902; A.R.S. §32-924*
- **Diagnostic Studies and Imaging:** Diagnostic testing results and imaging reports should be maintained when obtained. *Authority: A.A.C. R4-7-902; A.R.S. §12-2297*
- **Daily Visit Documentation:** Each visit note should identify the patient name, date of service, clinical findings, services performed, and the provider rendering care. *Authority: A.A.C. R4-7-902; A.R.S. §32-924*
- **Billing Must Match Documentation:** Billing entries should be supported by the clinical record and documented services. *Authority: A.R.S. §32-924; A.A.C. R4-7-902*
- **Document Informed Consent and Medical Necessity:** Failure to document informed consent or medical necessity is a common Board concern. *Authority: A.A.C. R4-7-902*
- **Avoid Common Documentation Problems:** Common deficiencies include cloned notes, incomplete records, unsupported billing, altered records without notation, and late entries. *Authority: A.A.C. R4-7-902*

- **Continuity of Care:** Records should contain sufficient information for another provider to understand the patient's condition, prior care, and ongoing treatment needs. *Authority: A.R.S. §12-2295(B)(1)*

Practical Takeaways

- Most Board complaints are behavior-driven and preventable.
- Intent does not always equal patient perception.
- Professionalism, humility, and communication reduce risk.
- Good documentation is both a clinical and legal safeguard.
- If it is not documented, regulators may conclude it did not occur.

This handout is educational in nature and summarizes information derived from Arizona statutes, administrative rules, published literature, and presentation content prepared by . Wayne Bennett, DC, DABCO