

welcome

Personal Information

Name: _____ Today's Date: _____
Last First MI Mr Mrs Ms Dr

Home Address: _____
Street City State Zip

Telephone: (____) _____ Social Security #: _____ Driver's License #: _____

Age: _____ Birthdate: ____/____/____ Sex: Male Female Status: Married Single Widowed Divorced Number of Children: _____

Occupation: _____ Employer: _____ Wk#: (____) _____ Years Employed: _____

Spouse Name: _____ Occupation: _____ Employer: _____ Social Security #: _____

Person Responsible for this account: _____ Health Plan: _____

Subscriber's Name: _____ ID#: _____ Group#: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? Intermittently Occasionally Frequently Constantly
 Describe your current pain/symptoms: Sharp/Stabbing Throbbing Aches Weakness

Dull Soreness Shooting Gripping Other _____
 Numbness Tingling No Change

Since it began, is your problem: Improving Getting Worse Walking Movement Other _____
 What makes the problem better? Nothing Lying Down Walking Movement

What makes the problem worse? Standing Sitting Other _____
 Exercise Inactivity/Rest Walking Movement Other _____

Can you perform your daily home activities? Yes Yes, only with help Not at all
 Do you exercise? Yes, almost daily Yes, occasionally Not at all

Describe your job requirements: Mainly sitting Light Labor Heavy Labor
 Can you perform your daily work activities? Yes, all activities Only some Not at all
 Describe your stress level: None to mild Moderate High

What treatment(s) have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____

Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Example

Numbness **N**
 Pins & Needles **P**
 Burning **B**
 Aching **A**
 Stabbing **S**

Example

Right Side

Front Side

Back Side

Left Side

Present Weight _____ pounds Height _____ feet _____ inches

Current Medications _____

Do you have a permanent disability rating? Yes No

Hospitalizations/Surgical Procedures _____

Location _____

Date rating received _____/_____/_____

Rating percentage _____ %

Medical History

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the present column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past | Present | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in upper arm or elbow (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in upper leg or hip (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in lower leg or knee (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in ankle or foot (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/eczema/rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (ear noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable colon |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee/tea/caffeinated soft drinks: cups/cans per day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or alcohol dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco, frequency _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol, frequency _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth control pills, type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of pregnancies _____ |

If a family member has had any of the following, please mark the appropriate box:

- | | | | |
|--|---------------------|---|---------------------|
| <input type="checkbox"/> Cancer | Family member _____ | <input type="checkbox"/> High blood pressure | Family member _____ |
| <input type="checkbox"/> Chronic back problems | Family member _____ | <input type="checkbox"/> Lung problems | Family member _____ |
| <input type="checkbox"/> Chronic headaches | Family member _____ | <input type="checkbox"/> Lupus | Family member _____ |
| <input type="checkbox"/> Diabetes | Family member _____ | <input type="checkbox"/> Rheumatoid arthritis | Family member _____ |
| <input type="checkbox"/> Heart problems | Family member _____ | | |

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

FINANCIAL & INSURANCE INFORMATION

Patient Name: _____ **Patient Social Security Number:** _____ **Patient Birthdate:** ___/___/___

Primary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Chiropractic Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Insured's Name: _____
Street/PO Box City State Zip
 Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Chiropractic Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Insured's Name: _____
Street/PO Box City State Zip
 Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

 Signature Date

My method of payment will be: Cash Check Credit Card. Credit Card #: _____ Expiration Date: _____

 Signature Date

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care.

I, (We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

 Signature of Patient Date

 Signature of Insured Date

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

Patient Signature

Date _____ / _____ / _____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.