PERSONAL INJURY INSURANCE INFORMATION

PATIENT NAME: _____

DATE OF ACCIDENT: _____

STATE WHERE ACCIDENT HAPPENED: _____

AUTO: _____ WORKMAN'S COMP: _____

YOUR INSURANCE INFORMATION

INSURED'S NAME: _____

INSURANCE COMPANY: _____

ADDRESS WHERE CLAIMS WILL GO: _____

_____

CLAIM NUMBER: _____ ADJUSTER'S NAME: _____

PHONE NUMBER: _____ FAX NUMBER: _____

PHONE NUMBER: _____ FAX NUMBER: _____

SECOND PARTY INSURANCE INFORMATION

INSURED'S NAME: _____

DRIVER'S NAME: _____

INSURANCE COMPANY: _____

ADDRESS WHERE CLAIMS WILL GO: _____

_____

CLAIM NUMBER: _____ ADJUSTER'S NAME: _____

PHONE NUMBER: _____ FAX NUMBER: _____

ATTORNEY'S INFORMATION

NAME: _____

FIRM'S NAME: _____

ADDRESS: _____

_____

PARALEGAL'S NAME: _____

PHONE NUMBER: _____ FAX NUMBER: _____

Patient Name _____ Date _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the : ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle...

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

_____

Patient Name _____ Date _____

After Injury

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D ☐ D.O ☐ D.D.S

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/	☐ Lower back pain
☐ Blurred vision	☐ Tension	fingers	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Chest pain	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/ toes
		☐ Stomach upset	

☐ Other _____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Patient Name _____ Date _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	☐	☐	☐
Lying on side.....	☐	☐	☐
Lying on stomach.....	☐	☐	☐
Sitting.....	☐	☐	☐
Standing.....	☐	☐	☐
Stretching.....	☐	☐	☐
Lovemaking.....	☐	☐	☐
Walking.....	☐	☐	☐
Running.....	☐	☐	☐
Sports.....	☐	☐	☐
Working.....	☐	☐	☐
Lifting.....	☐	☐	☐
Bending.....	☐	☐	☐
Kneeling.....	☐	☐	☐
Pulling.....	☐	☐	☐
Reaching.....	☐	☐	☐

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above
☐ Walking	☐ Crawling	head
☐ Lifting	☐ Bending	☐ Typing
		☐ Stooping

☐ Other _____

Patient Name _____ Date _____

What positions can you work in with minimum physical effort and for how long?

_____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse

DOCTOR'S LIEN
AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

VanNess Chiropractic
215 S. Northwest Hwy., Ste. 102A
Barrington, IL 60010
(847)842-8070

Doctor/Clinic Name and Address

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

* * * * *

INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____
Firm Name

_____
Attorney Name

_____
Patient Signature

_____
Date

* * * * *

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

_____
Attorney Signature

_____
Date

VanNess

Chiropractic • Massage • Rehabilitation

Date:_____

PERSONAL AND FAMILY HEALTH HISTORY

Full Name:_____ **I prefer to be called:** _____

Spouse/Guardian:_____

Address:_____
STREET CITY STATE ZIP

Date of Birth:___/___/___**Age:**_____**Married**_____**Single**_____**Widow(er)**_____

Names of Children		Under Previous Chiropractic Care	Reason / Wellness
Name:_____	Age_____	Y/N	_____
Name:_____	Age_____	Y/N	_____
Name:_____	Age_____	Y/N	_____
Name:_____	Age_____	Y/N	_____

Home Tel :(___) _____**Work Tel :(___)**_____**Cell:(___)**_____

Last 4 of Soc. Sec. #:_____ **(Will be your pin for Chirotouch check in) *Children use primary parent**

E-Mail Address: _____

Preferred means of appointment reminders:
TEXT / E-MAIL ***if text - cell phone carrier needed:_____

Height: _____ **Weight:** _____ **most recent blood pressure (if known):**_____

Occupation: _____**Employer:**_____

Employer Tel: (___) _____**Full Time** ___**Part Time**___ **Pregnant?** _____

Emergency Contact: _____
NAME PHONE

Spouse's Employer: _____
NAME PHONE

Who may we thank for referring you to us:_____
Referral:_____ **Insurance Co:** _____
Internet: _____ **Groupon/Living Social:** _____ **Other:**_____

Have you ever been to a chiropractor before? _____**If yes,** _____
DR.'S NAME LAST VISIT?

Date of last physical exam:_____**By whom:**_____**Family doctor:**_____

Other physicians consulted in past 12 months: _____

NAME **DIAGNOSIS**

Accidents and/or injuries related to current symptoms:

_____

ACCIDENT OR INJURY DATE OTHER IMPORTANT INFO. REGARDING INJURY

(IF AN AUTO, WORK OR PERSONAL INJURY, PLEASE REQUEST INSURANCE FORMS FROM FRONT DESK)

Reason for Seeking Care: Please make us aware of all issues of concern today. (i.e. acute conditions, nagging sports injuries, headaches, stress, internal imbalances, arthritis, numbness, etc.)

Primary Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____ Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**
- **Have you ever had this discomfort before (if yes, explain):_____**

Secondary Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____ Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**
- **Have you ever had this discomfort before (if yes, explain):_____**

Third Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____ Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**
- **Have you ever had this discomfort before (if yes, explain):_____**

Additional information you would like to share with the doctor:

_____

_____

_____

_____

Daily Activities: Effects of Current Condition on Performance: (1= No limitations – 10=Unable to Perform)

Carrying Groceries:	1	2	3	4	5	6	7	8	9	10
Changing Positions:	1	2	3	4	5	6	7	8	9	10
Climbing Stairs:	1	2	3	4	5	6	7	8	9	10
Computer Strain:	1	2	3	4	5	6	7	8	9	10
Driving:	1	2	3	4	5	6	7	8	9	10
Household Chores:	1	2	3	4	5	6	7	8	9	10
Lifting Children:	1	2	3	4	5	6	7	8	9	10
Pet Care:	1	2	3	4	5	6	7	8	9	10
Reading/Concentration:	1	2	3	4	5	6	7	8	9	10
Self-care: Bathing:	1	2	3	4	5	6	7	8	9	10
Self-care: Dressing	1	2	3	4	5	6	7	8	9	10
Self-care: Shaving	1	2	3	4	5	6	7	8	9	10
Sexual Activities:	1	2	3	4	5	6	7	8	9	10
Sitting Still:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Standing Still:	1	2	3	4	5	6	7	8	9	10
Walking:	1	2	3	4	5	6	7	8	9	10
Yard work:	1	2	3	4	5	6	7	8	9	10

Pertinent personal and family history: of illness, disease or chronic health conditions?
Mark :(S) For Self (F) for Family

____Alcoholism	____Cancer	____Gastric Reflux	____High Cholesterol	____Pacemaker
____Allergies	____Constipation	____Gout	____Irregularity	____Parkinsons Disease
____Anemia	____Degenerative Discs	____Headaches	____Kidney Disease	____Pinched Nerve
____Appendicitis	____Depression	____Heart Disease	____Liver Disease	____Pneumonia
____Arthritis	____Diabetes	____Hepatitis	____Miscarriage	____Prostate Problems
____Asthma	____Emphysema	____Hernia	____Multiple Sclerosis	____Stroke
____Auto Immune	____Epilepsy	____Herpes	____Muscle Spasms	____Thyroid Problems
____Backaches	____Fractures	____Herniated Disc	____Osteoporosis	____Tumors
____Bronchitis	____Gallbladder	____High Blood Pressure	____Other: _____	

List all Surgeries:

_____

List all Medications/Vitamins:

_____

Alcohol: □ Daily □ Weekly □ Occasional □ Never
Smoking: □ Daily □ Weekly □ Occasional □ Never
Caffeine: □ Daily □ Weekly □ Occasional □ Never
Exercise: □ Daily □ Weekly □ Occasional □ Never
Pain Meds: □ Daily □ Weekly □ Occasional □ Never
Diet: □ Good □ Fair □ Poor
Sleep: □ Back □ Side □ Stomach □ Firm mattress □ Soft mattress □ other: _____
Allergies (Food / Seasonal / Meds / Latex): _____
Breast Implants? □Yes □No

Do you expect health insurance to contribute to your care? Y / N
Health Insurance Carrier: _____

Our goal at Van Ness Chiropractic is to provide complete care for you, your spouse and your children. Please make us aware of any injuries, birth trauma, growth and developmental concerns or recurrent childhood conditions regarding your spouse or children.

_____

_____

_____

Given your current understanding of chiropractic what are your goals for care?
__ Just pain relief
__ Pain relief, plus improved spinal posture
__ Pain relief, improved spinal posture, plus long term increased vitality and spinal wellness

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT COLLECTION EFFORTS BECOME NECESSARY, I AGREE TO PAY ALL COLLECTION COSTS, UP TO 40% REASONABLE ATTORNEY FEES, AND COURT COSTS. I ALSO AGREE TO PAY INTEREST AFTER 30 DAYS AT 5% MONTHLY ON ANY UNPAID AMOUNTS.

SIGNATURE OF PATIENT OR GUARDIAN_____

In special circumstances, other arrangements will be made to accommodate your health care needs regardless of your ability to pay. Simply talk to the doctor.

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Van Ness
Chiropractic • Massage • Rehabilitation
215 S. Northwest Hwy, Suite 102A, Barrington, IL 60010

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Height: _____ **Weight:**_____ **Blood Pressure:**_____/_____

Patient Signature: _____ Date:_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy or your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You many not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____Signature_____Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine inappropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent and inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.