___________________________ (Patient Name – Please Print)

________________ (Date)

Patient Intake Form

Welcome to our practice. Please take your time and answer all questions thoroughly and print clearly.

Name: ____ Race:_________________ Sex: M F R L B Handed

Street:____ City/State/Zip: _______________________________________

Phone H:__________________ W:__________________ C:__________________ Email:_____________________________

DOB: (mm/dd/yyyy) __________________ Age:________ Blood type:______________ Ht:________ Wt:________

Married / Divorced / Single / Widowed / Separated

Emergency Contact's Name and #: ____

Occupation: _________________________ Occupational Stresses: (chemical, physical, psychological, etc.): ____________

____

Denomination/Spiritual Path: _____________________ Hobbies/Pastimes: _______________________________________

____

Referred by: ___________________________ Physician: ____________________________ Phone: __________________

Main Concern/Health Issue: ____

How does it affect your daily living? ____

____

Please answer all questions as completely and thoroughly as you can. Though some questions may not seem relevant, they all are very important to help diagnosis and formulate a treatment plan specifically for you and make proper referrals. If needed, use the list number, then use spaces or back of page to explain in more detail.

Recent Exam Dates: Physical: ___________________ Eye: _____________________ Dental: ___________________

Ob/Gyn: __________________ Specialist (Date & Type) __________________ Specialist (Date & Type) __________________

What is your philosophy of healthcare? ____

Do you have health questions that do not get answered at the doctor's office? Y N Explain: ______________________

____

____

Wellness Survey

Your Physical health status now feels: (poor) 1---10 (ideal)

Your Mental health status now feels: (poor) 1---10 (ideal)

Your Daily Work stress levels now feel: (poor) 1---10 (ideal)

Your Daily or Social stress levels feel: (poor) 1---10 (ideal)

Your Home Life stress levels now feel: (poor) 1---10 (ideal)

Your ability to handle recent stresses: (poor) 1---10 (ideal)

What special topic/s would you like to ask about at your consultation? ____

____

______________________________ (Patient Name – Please Print)

________________ (Date)

Healthcare: Other independent or concurrent therapies: Past (P) and/or Current (C)

1. ____ Chiropractic
2. ____ Chiro for family or pets
3. ____ Acupuncture
4. ____ Therapeutic massage
5. ____ Naturopathic
6. ____ Oriental medicine
7. ____ Nutritional consult
8. ____ Medical treatment
9. ____ Specialist: _____________
10. ____ Natural healer
11. ____ Spiritual healer
12. ____ Energy work

____

Diagnostic or Routine Exams: Please list area, Dr., reason ordered, date, and location of exam if known.

13. ____ X-rays
14. ____ MRI
15. ____ CAT scan
16. ____ Blood draw
17. ____ Ultrasound
18. ____ Upper/lower GI
19. ____ DEXA scan
20. ____ Breast exam
21. ____ Prostate exam
22. ____ Eye exam
23. ____ Dental exam
24. ____ Colonoscopy
25. ____ Other______________
26. ____ Other______________
27. ____ Other______________

____

____

Medical History: Current = C Past = P *(greater than 6 months)* – Include dates for both if possible.

Significant Illness:

28. ____ Allergies
29. ____ Arthritis
30. ____ Asthma
31. ____ Cancer
32. ____ Depression
33. ____ Diabetes
34. ____ Hepatitis A / B / C
35. ____ Heart disease
36. ____ High blood pressure
37. ____ Low blood pressure
38. ____ Lung disease
39. ____ Neurological
40. ____ Psychological
41. ____ Rheumatic fever
42. ____ Seizures
43. ____ Thyroid disease
44. ____ Vascular disease
45. ____ Other

____

____

Illness/Injuries/Surgeries/Hospitalizations:

46. ____ Broken bones
47. ____ Burns
48. ____ Car accidents
49. ____ Concussion
50. ____ Fallen down/upstairs
51. ____ Fallen from any height
52. ____ Fallen on ice
53. ____ Feeling un-coordinated
54. ____ Fevers
70. ____ Transplants
71. ____ Tripping/stumbling
55. ____ Flu/colds
56. ____ Frequent accidents or sports injuries
57. ____ Frequent illness
58. ____ Frequent Infections
59. ____ Head trauma
60. ____ Hospitalizations
61. ____ Infected wounds
62. ____ Loss of consciousness
72. ____ Wounds slow to heal
63. ____ Psychological hospitalization
64. ____ Recreational injuries
65. ____ Serious cuts
66. ____ Serious depression
67. ____ Significant trauma
68. ____ Surgeries
69. ____ Transfusions

____

____

Childhood:

73. ____ Illnesses
74. ____ Traumatic events
75. ____ Immunizations

____________________________ ________________
(Patient Name – Please Print) (Date)

76. ____ Injuries
77. ____ Other
78. ____ Other

____

____

Current Prescriptions/Over the Counter Medications and/or Supplements *(Include doses, purpose and duration):*

____

____

Past Medications and Supplements (3-6 months ago):

____

Why did you stop taking these? ____

Skin and Hair: List location and duration as applicable.

79. ____ Rashes
80. ____ Eczema
81. ____ Hair/skin texture change
82. ____ Ulcerations
83. ____ Pimples
84. ____ Purpura
85. ____ Hives
86. ____ Dandruff
87. ____ Itching
88. ____ Loss of hair
89. ____ New moles/growth
90. ____ Other

____

____

General: List any times of day and any correlating factors.

91. ____ Poor appetite
92. ____ Heavy appetite
93. ____ Change in appetite
94. ____ Weight gain
95. ____ Weight loss
96. ____ Cravings salt/sweet/fats
97. ____ Poor sleep
98. ____ Can't fall asleep easily
99. ____ Wake feeling rested
100. ____ Decreased sleep
101. ____ Heavy sleep
102. ____ Insomnia
103. ____ Apnea/Narcolepsy
104. ____ Sudden awakening at night, time________________
105. ____ Hours of sleep/night
106. ____ Day napping ____ amt
107. ____ Night sweats
108. ____ Cold hands/feet
109. ____ Sudden energy drop
110. ____ Strong thirst hot/cold
111. ____ Fatigue
112. ____ Chills
113. Sudden temp changes
114. Localized weakness
115. ____ Tremors
116. ____ Poor circulation
117. ____ Peculiar tastes/smells
118. ____ Night pain
119. ____ Radiating pain
120. ____ Numbness/tingling
121. ____ Pins and needles
122. ____ Sweats easily
123. ____ Excessive sweating
124. ____ Body odor change
125. ____ Stress
126. ____ Bowel/bladder changes
127. ____ Bleed/bruise easily – If, so, where? ________________

____

____

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc.

128. ____ Neck pain
129. ____ Muscle pain
130. ____ Back pain
131. ____ Joint pain
132. ____ Other muscle or joint problems – List/explain
133. ____ Irretractable night pain
134. ____ Scar tissue adhesions

____

Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency these conditions occur

135. ____ Dizziness
136. ____ Migraines
Auras, Sounds, Smells
137. ____ Headaches
138. ____ Vision problems
139. ____ Near/Far sighted

____
(Patient Name – Please Print)

____
(Date)

140. ____ Blurry vision
141. ____ Night Blindness
142. ____ Eye strain/pain
143. ____ Color blindness
144. ____ Cataracts
145. ____ Glaucoma
146. ____ Spots in eyes
147. ____ Ringing in ears
148. ____ Poor hearing
149. ____ Earaches
150. ____ Ear Pain
151. ____ Ear discharge
152. ____ Heavy ear wax
153. ____ Nose bleeds
154. ____ Sinus problems
155. ____ Mucus
156. ____ Dry throat/mouth
157. ____ Copious saliva (lots)
158. ____ Mouth/tongue sores
159. ____ Sore throats
160. ____ Other

Dental:

161. ____ Teeth problems
162. ____ Cavities
163. ____ Braces
164. ____ Bridges
165. ____ Fillings/amalgams
166. ____ Crowns gold/porcelain
167. ____ Tooth pain
168. ____ Head pain
169. ____ Jaw pain
170. ____ Molars
171. ____ Extractions
172. ____ Surgeries
173. ____ Jaw clicks
174. ____ Grinding teeth
175. ____ Facial pain
176. ____ Implants
177. ____ Dentures
178. ____ Swollen/bleeding gums
179. ____ Periodontal Tx
180. ____ Sealants
181. ____ Fluoride Tx
182. ____ Dry mouth
183. ____ Other________________
184. ____ Other________________

Neurologic:

185. ____ Balance problems
186. ____ Vertigo
187. ____ Nausea
188. ____ Vomiting
189. ____ Sudden blurry vision
190. ____ Loss of consciousness
191. ____ Loss of strength
192. ____ Weakness limb/body
193. ____ Feel un-coordinated
194. ____ Stumbling/tripping
195. ____“Running into walls or things”
196. ____ Frequently dropping things
197. ____ Loss of hand grip
198. ____ Loss of fine motor skills
199. ____ Other________________
200. ____ Other________________

Cardio Vascular:

201. ____ High blood pressure
202. ____ Dizziness
203. ____ Blood Clots
204. ____ Low blood pressure
205. ____ Fainting
206. ____ Phlebitis
207. ____ Chest Pain
208. ____ Cold hands/feet
209. ____ Difficulty breathing
210. ____ Irregular heartbeat
211. ____ Hand/feet swelling
212. ____ Rapid pulse
213. ____ Heaviness in chest
214. ____ Other ______________
215. ____ Other_______________

Respiratory and Lungs:

216. ____Persistent Cough
217. ____ Coughing Blood
218. ____ Difficulty breathing while lying down
219. ____ Asthma
220. ____ Production of phlegm Y / N _____Color
221. ____ Tight chest
222. ____ COPD

223. ____ Bronchitis
224. ____ Pneumonia
225. ____ Asthma
226. ____ Other

Genito-Urinary:

227. ____ Pain w/urination
228. ____Loss of bladder function
229. ____Wake to urinate:
     ____ x's/ night; time:________
230. ____ Kidney stones
231. ____ Frequent urination:
     ________________ color
     ________________odor
232. ____ Kidney stones
233. ____ Blood in urine
234. ____ Venereal disease/STD
235. ____ Urgency to urinate
236. ____ Impotency
237. ____ Prostate problems
238. ____ Other ____________

Gastrointestinal:

239. ____ Nausea
240. ____ Gas/bloating
241. ____ Bad breath
242. ____ Constipation
243. ____ Diarrhea
244. ____ Pain or cramps
245. ____ Vomiting
246. ____ Belching
247. ____ Rectal pain
248. ____ Bloody stools:
     bright or dark red
249. ____ Hemorrhoids
250. ____ Sensitive abdomen
251. ____ Laxative use:
     #______week; type:_________
252. ____ Bowel changes
253. Bowel movements:
     # _______day/week
     _______color
     _______odor (foul)
     _______ form (loose/ compact)
     ____texture (smooth/segmented)
254. ____Other: ____________

Gynecology and Pregnancy:

255. ____ Age of 1st menses
256. ____ Flow (describe)
257. ____ Period ___ days
258. ____ Clots
259. ____ Vaginal sores
260. ____ Vaginal discharge:
     ________________odor
     ________________color
     ________________appearance
261. ____ Irregular periods
262. ____ Last menses
263. ____ Birth control type and
     duration _________________
264. ____ Number of pregnancies
265. ____ Number of births
266. ____ Live births
267. ____ Premature births: ______
     Length of pregnancy: ________
268. ____ Miscarriages: __________
     Month/week: ______________
269. ____ Breast lumps or
     tenderness
270. ____ PMS
271. ____ Mood changes
272. ____ Body changes
273. ____ Cramps
274. ____ Bloating
275. ____ Nausea
276. ____ Vomiting
277. ____ Menopause: __________
278. ____ Last PAP: _____________
279. ____ Last breast exam: ______
280. ____ Last Ob/GYN appt:______

Appliances or Aids:

281. ____ Glasses/prisms
282. ____ Contacts
283. ____ Orthotics
284. ____ Joint replacement
285. ____ Prosthetics
286. ____ Implants of any kind
287. ____ Braces
288. ____ Splints
289. ____ Pace maker

290. ____ Hearing aids
291. ____ Other
292. ____ Other

Neuropsychological:

293. ____ Seizures
294. ____ Depression
295. ____ Anxiety
296. ____ Poor memory
297. ____ Foggy thinking
298. ____ Bad Temper
299. ____ Concussions
300. ____ Easily stressed
301. ____ Considered/attempted suicide
302. ____ Treated for emotional concerns
303. ____ Antidepressant medications
304. ____ Other neurological or psychological concerns

Lifestyle and Social History

Stress Screening:

305. ____ Can you relax when you want?
306. ____ Fall asleep easily?
307. ____ Stay asleep all night?
308. ____ Have trouble dealing with stress?
309. ____ Are you in therapy or counseling? Does it help?
310. ____ Is your family safe to express true emotions?
311. ____ Are romantic relationships fulfilling?
312. ____ Does stress lead to digestive problems?
313. ____ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
314. ____ Do you vent unpleasant emotions in a satisfying way?
315. ____ Do you avoid conflicts at your expense?
316. ____ Do you feel your health is out of your hands?
317. ____ Have you tried to deal with stress, but couldn't succeed?
318. ____ Do you feel capable of resolving your problems, but simply need to know how?
319. ____ How much do you love yourself? 0---------------------------------------100%

<u>Do you find any dysfunction or concern in the following areas:</u>

320. ____ Relationship with family
321. ____ Relationships with friends
322. ____ Social Skills
323. ____ Career
324. ____ Work
325. ____ Leisure Time
326. ____ Hobbies
327. ____ Past time activities
328. ____ Intimate relationships
329. ____ Sex
330. ____ Religious Life___________
331. ____ Spiritual Path___________
332. ____ Childhood religious teachings
333. ____ Past relationships
334. ____ Childhood
335. ____ School

Habits: List type and quantities where needed

336. ____ Exercise x's/week____________________
337. ____ Proper diet - Please list typical daily meals below
338. ____ Participate in community events

______________________________ ________________
(Patient Name – Please Print) (Date)

339. ____ Sports: ________________
340. ____ Walks: ________________
341. ____ Regular religious activity
342. ____ Regular spiritual activity
343. ____ Seatbelts
344. ____ Helmets/protective gear
345. ____ Caffeine, pills, coffee, tea, drinks
346. ____ Consume alcohol
347. ____ Crave sugar/salt/fats
348. ____ Smoke/chew tobacco
349. ____ Recreational drugs use
350. ____ Un-protected sex
351. ____ Un-necessary risk taking
352. ____ Road rage
353. ____ Seek conflict

____

____

Nutritional: List typical ounces/servings per week and type. Use the space below if needed.

354. ____ Drink soda: ____________
355. ____ Fruit juices: ____________
356. ____ Gatorade: _____________
357. ____ Coffee/black tea: ________
358. ____ Caffeine: ______________
359. ____ Chocolate: _____________
360. ____ Alcohol: _______________
361. ____ Energy drinks: __________
362. ____ Nutritional shakes: ______
363. ____ Health bars: ____________
364. ____ Protein powders: _______
365. ____ Cravings: salt - sweet- fat: ____________________________
366. ____ Meat: _________________
367. ____ Protein: _______________
368. ____ Milk: _________________
369. ____ Dairy – what kind: ____________________________
370. ____ Veggies – serving/day: ____________________________
371. ____ Fruits – serving/day: ____________________________
372. ____ Vitamins: ______________
373. ____ Supplements: ____________________________
374. ____ Food allergies: ____________________________
375. ____ Other: ________________
376. ____ Other: ________________

____

Family History: Medical, psychological, and social

377. ____ History of chief complaint
378. ____ Anemia
379. ____ Alcoholism
380. ____ Allergies
381. ____ ALS (Lou Gerhig's)
382. ____ Arthritis
383. ____ Asthma
384. ____ Back/spine problems
385. ____ Cancer
386. ____ Dementia/Alzheimer's
387. ____ Depression
388. ____ Diabetes
389. ____ Family violence
390. ____ Headaches
391. ____ Heart Disease
392. ____ High blood pressure
393. ____ High cholesterol
394. ____ Low cholesterol
395. ____ Lung disease
396. ____ Mental abuse
397. ____ Mental illness
398. ____ Migraines
399. ____ Multiple Sclerosis
400. ____ Muscular Dystrophy
401. ____ Neglect
402. ____ Neuropathy (numbness, tingling, pain, burning)
403. ____ Neuromuscular disease
404. ____ Parkinson's
405. ____ Physical abuse
406. ____ Sexual abuse
407. ____ Seizures
408. ____ Rigid upbringing
409. ____ Rigid religious beliefs
410. ____ Stroke
411. ____ Suicide (or attempted)
412. ____ Thyroid disease
413. ____ Tremors
414. ____ Vascular disease
415. ____ Other_______________
416. ____ Other____________

____

Patient Signature: ____ Date:_____________________

______________________________ __________________

(Patient Name – Please Print) (Date)

Informed Consent

Some risk is assumed in all treatment modalities, including chiropractic adjustments. Manipulation or adjustment of the human frame carries small risk of injury to weakened or hidden pathology of the vertebral artery in the neck causing death or stroke in reported 1 per 400,000 cases to 1 per 10 million cases. Every effort is made to screen for this and use methods with the lowest risk. Your doctor of chiropractic is the highest licensed professional for specific and safe adjustment of the human frame.

Other complications may rarely include; strain, sprain, dislocation, fracture, disk aggravation, physiotherapy burns, muscle soreness, aches, or other injury. Please ask your doctor of chiropractic if you have any questions.

Subluxation is a misalignment and/or "stuck" joint or tissue, which is found to cause nerve impingement. This interferes with any organ, tissue, or blood vessel supplied by that nerve. Your doctor of chiropractic is trained to look for and find these subluxations, and to correct them with an adjustment. Please do not "pop" or "crack" your joints using a thrust of any kind, nor have an unlicensed person do it for you. Not only can you be hurt, you most likely will not achieve the correction you are looking for. Proper stretching can be very beneficial, and painless popping sounds may be heard and are normal, as long as no forceful thrust or impulse is applied.

After a specific adjustment some people experience the effects of renewed nerve flow and circulation to impinged areas that were restricted by their subluxation. These historically have been changes in; sweating patterns, increased respiratory capacity, faster bowel transit time, increased bowel movement frequency, shift in center of balance perception, sleep pattern changes, shoe fit and clothing measurements, differences in walking (gait), and various organ function changes. These subside quickly as the tissue adjusts itself to the restored nerve flow, but may be temporarily necessary in order for the tissue cells to excrete stored wastes.

____

Patient Signature

Date______________

I understand the informed consent and hereby consent to treatment of my minor child named_______________________________________.

Child's date of birth: ______________________

Parent or guardian signature:

____

Date_____________

(Patient Name – Please Print) (Date)

Chief Complaint Worksheet

Symptom/Complaint:

Onset (What caused it & When did it begin?):

Provoke (What worsens the complaint: position, activity, stress, food/drinks, motion, etc.?):

Palliative (What makes it better: ice, OTC, massage, position?):

Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general):

Radiation (Does the pain travel from one area to another?):

Reference: What is the worse pain you've ever experienced?

Severity:	At Its Worse: 0 1 2 3 4 5 6 7 8 9 10	Percent of time:	At Its Best: 0 1 2 3 4 5 6 7 8 9 10	Percent of time:

Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Possible Social Factor Correlation:

Possible Hospitalization Correlation:

Possible Infection Correlation:

Possible Traumatic Correlation:

Possible Surgical Correlation:

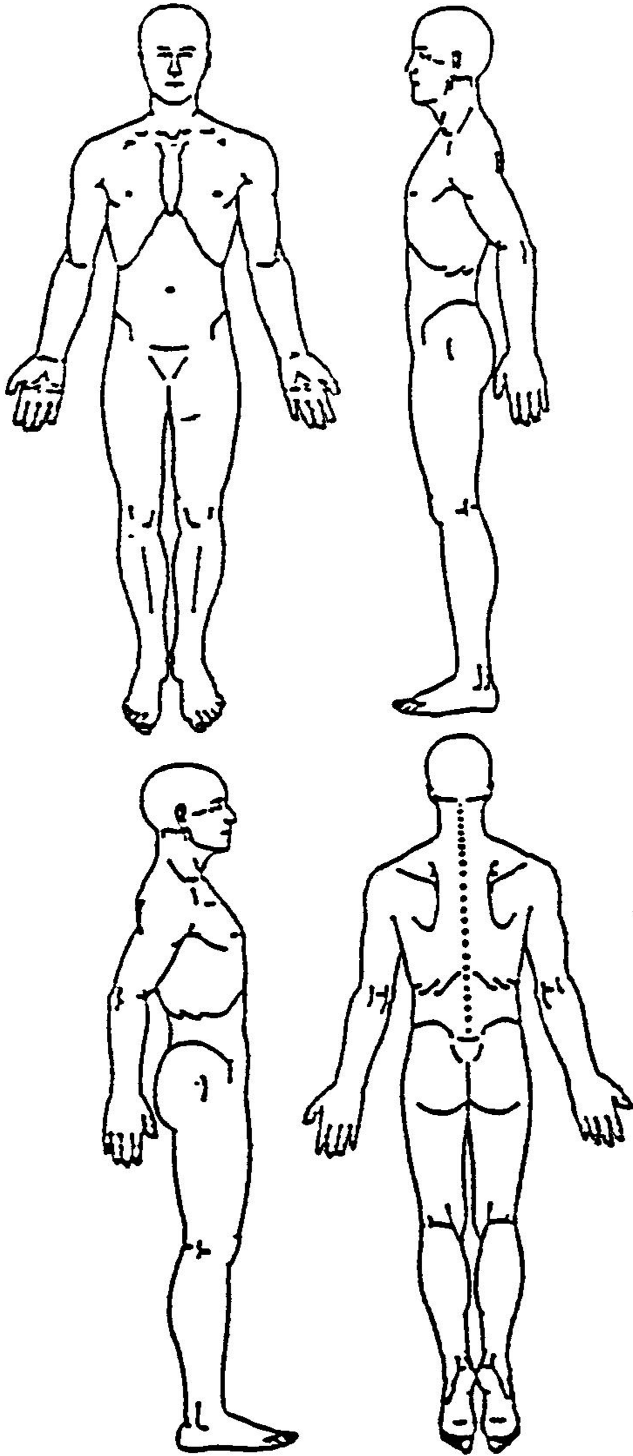
Possible Medication Correlation:

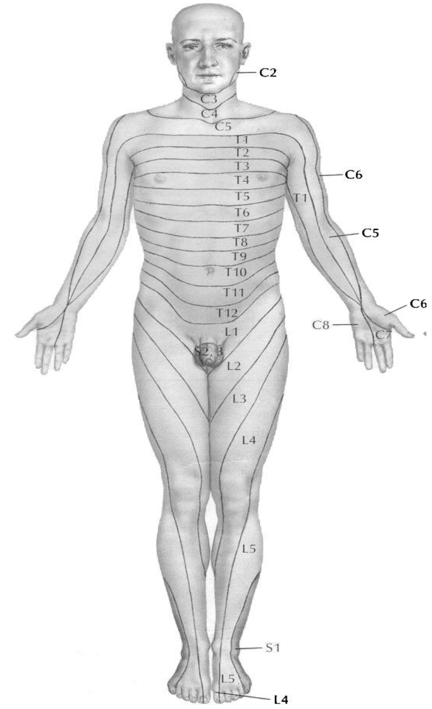
Possible Genetics Correlation:

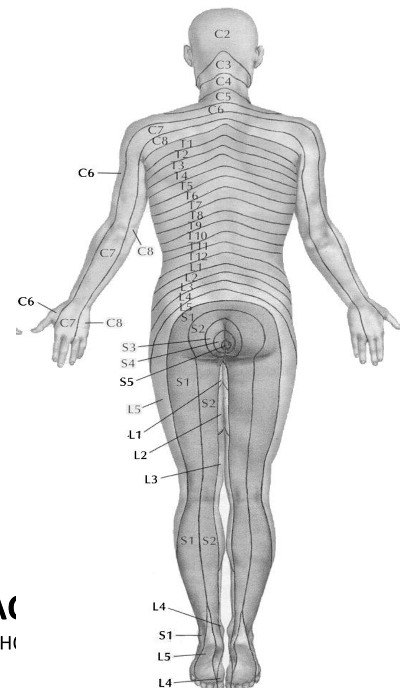
Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant:

____________________________ ________________

(Patient Name – Please Print) (Date)







HIPAA NOTICE OF PRIVACY PRA(

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND H(ION. PLEASE REVIEW IT CAREFULLY.

___________________________ ________________
(Patient Name – Please Print) (Date)

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Open Therapy Policy

This office utilizes an “open-therapy” environment for on-going patient care. Patients are in sight of one another during exercise and/or modality therapy service and some on-going routine details of care are discussed within earshot of other patients and staff. This is NOT the environment used for taking the initial patient history and examination or presenting reports of findings, these procedures are held in a private confidential setting. If you choose to not receive therapy in this format, please notify the staff or doctor and other arrangements will be made for you.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.
Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)
Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
Request copies of your PHI in electronic format if this office maintains your records in that format.
Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
Receive notice of any breach of confidentiality of your PHI by the Practice
Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to: maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI, and abide by the terms of this Privacy Notice. The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains; will distribute any revised Privacy Notice to you prior to implementation; and, will not retaliate against you for filing a complaint.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (Printed): ____

Patient Signature:____ Date: ___________________

_____________________________ _________________

(Patient Name – Please Print) (Date)

Financial Agreement & Payment Options

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policies of this office, we would like to explain how your medical bills will be handled. This information will enable us to better serve you and help us to avoid misunderstandings in the future. Please read carefully and choose the plan which best suits your needs.

It is the policy of Momentum Health & Wellness Institute that payment is due at the time of service unless other financial arrangements are made in advance.

PLAN ONE: The **self-pay** plan means that all fees will be paid at the time of services rendered. This office accepts cash, check, and all major credits. This office also accepts CareCredit.

Please note: *Any returned checks will be assessed with a _______ fee.*

Please note: *Certain services that are performed in this office are covered as cash only including: qEEG (Brain Scans), Neurofeedback, Functional Medicine, Comprehensive Neurology Exams, Weight Loss, and most massage services.*

PLAN TWO: If you have **insurance**, we will do our best to verify your insurance coverage and bill your insurance in a timely manner as a courtesy to you. *Payments for a patient's deductible, if it has not yet been met, is the responsibility of the patient, as well as any remaining balance after insurance payment. Copayments are due at the time of services rendered.*

Please note*: Many insurance policies do cover chiropractic care, but this office makes no representation that yours does. Momentum Health & Wellness Institute only accepts PPO healthcare plans that have coverage for Out of Network providers. Although your insurance plan may include chiropractic services, we are not contracted with most insurance carriers and are, therefore, considered "out of network". Being referred to our clinic by another physician does not guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred. Your physician's referral and/or our verification of your insurance benefits are not a guarantee of payment.*

Release of Information and Assignment of Benefits

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

By signing on the line below you are also authorizing payment of medical benefits to be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

I have read and agree to the above Release of Information and Assignment of Benefits.

____ _____________________

Patient Signature Date

___________________________ ________________

(Patient Name – Please Print) (Date)

PLAN THREE: If you have insurance, but choose to pay for your visits in full, we will be happy to supply you with a **"Superbill"** to submit to your insurance company for potential reimbursement. *If you choose this plan, you will pay for services rendered and the required documentation will be provided to you as a courtesy so that you may bill your insurance company directly.* The services incurred in this office will not be reported by us, the provider, and any payment your insurance carrier covers will be sent to you directly.

PLAN FOUR: If you have a ***Medicare Plan****, this office would be happy to bill Medicare on your behalf. All copayments will be due at the time of services rendered.*

Please note: *Medicare* ***only*** *covers manipulation of the spine. All other services are not covered and will be your responsibility.*

Cancellations, and No-Show Policies: *Please provide our office with 24-hour notice to change or cancel an appointment. Same-day cancellations and/or not showing up for a scheduled appointment may result in a charge for the full price of that service.*

Refunds: *In the event a refund is due to the patient for any unused pre-purchased package, it is the policy of this office to refund the balance of any unused treatments at a per treatment cost that reflects the full price of the treatment and not any discount or special pricing.*

Balances: Regarding any outstanding balances, if your account is not paid within 90 days from the date of service (or from notification of patient responsibility by insurance), and no financial arrangements have been made, you may be held responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

We hope this answers any questions you might have concerning the financial policy of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you may have.

I understand that all responsibility for payment of services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered unless other arrangements have been made. Please designate which plan you would like to use and sign below to indicate your understanding of our financial policies.

____ ___________________

Patient Signature Date