

Patient Health Information Consent Form

(For Your Privacy)

We want you to know how your Patient Health Information (**PHI**) is going to be used at Monroeville Chiropractic Health Center (MCHC) and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name

Date

Application for Chiropractic Care

| | | | | |
|---|---|---|---------------------|-----|
| First Name | M.I. | Last Name | Social Security # | |
| Address | | City | State | Zip |
| Home Phone (Call First <input type="checkbox"/>) | Cell Phone (Call First <input type="checkbox"/>) | Work Phone (Call First <input type="checkbox"/>) | E-mail address | |
| Age | Date of Birth | Circle: Married Single Other: _____ | # of Children _____ | |

| | | |
|---|-------------------------------|-------|
| Your Occupation | Employer | City |
| Spouse's Occupation | Employer | |
| If needed, who to contact while you are here? | | Phone |
| Family Medical Doctor | Date last seen? (approximate) | |
| May we contact your doctor if needed, so that we may coordinate our efforts so that you receive the best care? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| How were you referred to our office? | | |

| | |
|---|--|
| Purpose of this appointment | Date symptoms appeared or accident happened? |
| Have you ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and describe: _____ | |
| Have you been treated for any health condition by a physician in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, describe: _____ | |
| What surgeries, serious illnesses, childhood illnesses, hospitalizations or broken bones have you had? (Include approximate dates) _____ | |
| What supplements, medications, or drugs are you taking? _____ | |
| Are you allergic to any supplements, medications, drugs, or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____ | |
| Are you interested in a complimentary nutritional consultation to address any questions that you might have? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

If you would like and we are able to use your insurance for payment, please provide us with the following information:

| | | | | |
|--|--------------------|-----------------------|------------|----------------|
| Name of Insurance Company | Group Number | Identification Number | | |
| Circle all that apply: Your Insurance | Spouse's Insurance | Medicare | Work Comp. | Auto Insurance |
| (If Work Comp. Or Auto, please complete an Accident/Injury Form) | | | | |

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care sustained in this office, regardless of insurance coverage and as agreed upon by the chiropractic office and myself. I also understand that if I suspend or terminate my schedule of care as agreed upon by myself and my treating doctor, any outstanding fees owed to the chiropractor or chiropractic office will be immediately due and payable. I UNDERSTAND THAT THIS DOCTOR AND OFFICE HAS ME, THE PATIENT IN THEIR BEST INTEREST AND THEREFORE WILL MAKE EVERY EFFORT POSSIBLE THAT ALL NECESSARY PAYMENT ARRANGEMENTS WILL BE MADE PRIOR TO BEGINNING CARE SO THAT MY HEALTH ALWAYS REMAINS THE PRIMARY FOCUS. NO PAYMENT WILL BE DUE UNTIL SERVICES ARE RENDERED.

| | |
|---|------------|
| Patient's Signature _____ | Date _____ |
| Guardian's Signature Authorizing Care _____ | Date _____ |

This form has three parts – please complete all three

ALTHOUGH YOUR SYMPTOMS DON'T TELL THE WHOLE STORY ABOUT YOUR HEALTH, IT IS STILL IMPORTANT TO TELL US WHERE THEY ARE LOCATED.

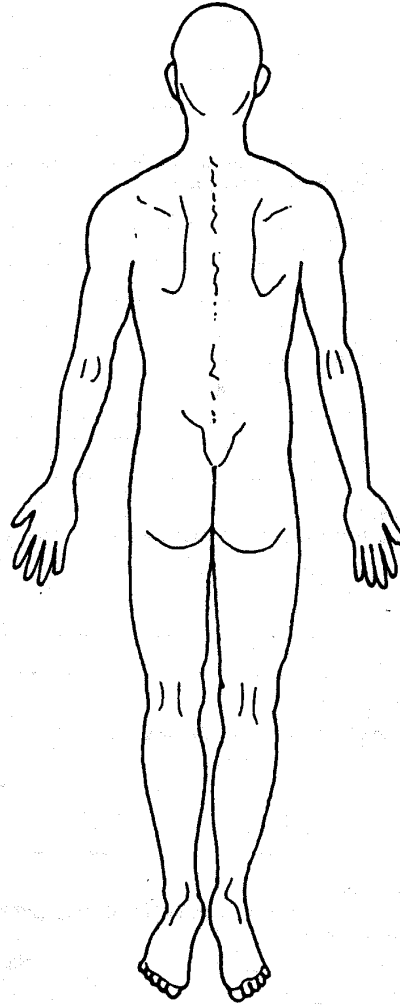
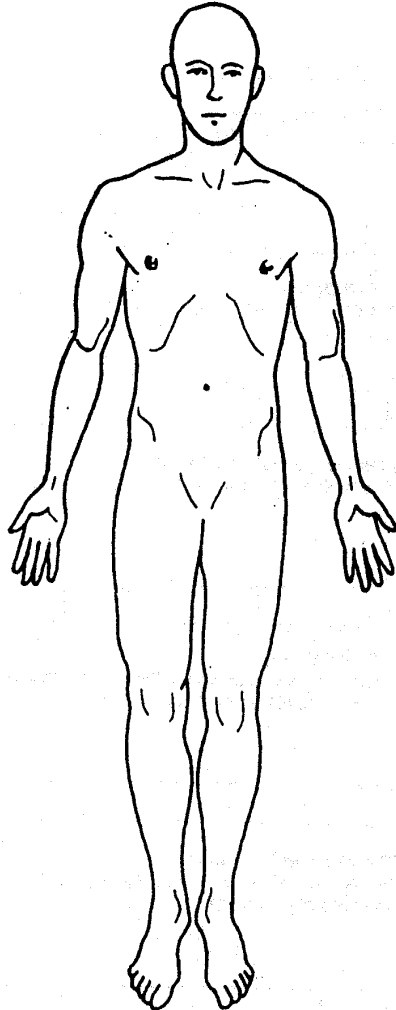
PART 1

Please read carefully:

Mark the areas on your body where you feel your symptom(s). Include all affected areas. Draw lines & use arrows for areas of pain or symptom movement. Use the appropriate symbol(s) listed below.

Ache = **A** Burning = **B** Numbness = **N** Stabbing = **S** Pins & Needles = **P** Throbbing = **T**

Feel free to write anything else where appropriate that might be helpful



PART 2

Please place an "X" on the line to indicate your level of problem.

**NO
SYMPTOMS**



**EXTREME
SYMPTOMS**

PART 3

I am interested in (check all that apply):

- Relief Care (gets rid of symptoms)
- Corrective Care (gets rid of symptoms plus stabilizes your problem for least chance of recurrence)
- Maintenance Care (Maintain the progress I make under the other types of care)

Patient Name _____

Date _____

HISTORY

Personal

Have you had or do you now have any of the following symptoms that are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions **Now** or **P** if you have had these conditions **Previously**.

Now = N Previously = P

- | | |
|--|--|
| <input type="checkbox"/> Headaches (Frequency _____ times per month / week / year) <input type="checkbox"/> Neck Pain <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Sleeping Problems <input type="checkbox"/> Back Pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Tension <input type="checkbox"/> Chest Pains/Tightness <input type="checkbox"/> Dizziness <input type="checkbox"/> Shoulder/Neck/Arm Pain <input type="checkbox"/> Numbness in Fingers <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Weakness in Extremities <input type="checkbox"/> Breathing Problems <input type="checkbox"/> Fatigue <input type="checkbox"/> Lights Bother Eyes <input type="checkbox"/> Ears Ring <input type="checkbox"/> Women: Are you pregnant | <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Unusual Bowel Patterns <input type="checkbox"/> Feet Cold <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Fever <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Indigestion Problems <input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> Menstrual Difficulties <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Depression <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Buzzing in Ears |
|--|--|
- OTHER: _____

Social

OFTEN = O SOMETIMES = S NEVER = N

- | | |
|--|--|
| <input type="checkbox"/> Vigorous Exercise <input type="checkbox"/> Moderate Exercise <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Caffeine | <input type="checkbox"/> High Stress Activity <input type="checkbox"/> Financial Pressures <input type="checkbox"/> Other Mental Stresses <input type="checkbox"/> Family Pressures <input type="checkbox"/> Other (specify) _____ |
|--|--|

Family

Indicate below by writing any family member(s) next to the condition(s) that they have been affected by:

(Example: Arthritis Mother)

| | | | |
|---------------------|------------------|-----------------|---------------|
| Arthritis | Constipation | Headaches | Liver Trouble |
| Pinched Nerve | Asthma-Hay Fever | Migraine | Diabetes |
| High Blood Pressure | Heart Trouble | Sinus Trouble | Back Trouble |
| Nervousness | Epilepsy | Insomnia | Disc Problem |
| Bursitis | Emphysema | Stomach Trouble | Scoliosis |
| Cancer | Neuritis | Kidney Trouble | Neuralgia |
| Other: _____ | | | |

TERMS OF ACCEPTANCE

Monroeville Chiropractic Health Center

Dr. James D. Smith

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

Signature

Date