GADSDEN FAMILY CHIROPRACTIC CENTER, LLC

Confidential Patient Health Information

Personal Information:

Mr. Mrs. Miss Name: _____ Age: ____ M F

Address: _____City/ST: _____ZIP:_____

SS#: _____/_____/_____Birthdate: ___ /____/____ Drivers License #: _____Marital Status: ____

Home Phone: ( ) ____-_____ Work Phone: ( ) _____-_____X____ Other Phone ( ) _____-_____

Employer: _____Occupation: _____ How Long? _____

Nearest Relative: _____ Relationship: _____ Phone: ( ) _____-_____

E-mail address (for Patient newsletter):_____

HOW WERE YOU REFERRED?_____

Reason for your Visit:

Have you been to this clinic before? Yes No

Purpose of this appointment_____

Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other

Please describe the pain and its location: _____

Date of accident/injury, or when condition began: _____/_____/_____

Is condition getting worse? Yes No Staying the Same Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other

Have you been treated by another doctor for this condition? Yes No

If yes, please name doctor/health care facility: _____

Insurance Information:

Company Name: _____ Phone: ( ) _____-_____

Address: _____City/ST: _____ZIP:_____

Name of Insured: _____ SS#: _____/_____/_____

Insured ID (if different than SS#): _____ Insured's Birthdate: ____/____/____

Policy/Group #: _____ Plan Name: _____

Relationship to you: _____ Insured's Employer: _____ Effective Date: ____/____/_____

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Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

General	Muscle & Joint	Eyes, Ears Nose & Throat	Gastrointestinal
C P Allergy	C P Arthritis	C P Hearing Loss	C P Colon Problems
C P Convulsions	C P Bursitis	C P Ear-ache	C P Constipation
C P Fatigue	C P Low Back Pain	C P Failing Vision	C P Diarrhea
C P Fainting	C P Neck Pain/Stiffness	C P Nosebleeds	C P Gall Bladder
C P Headache	C P Shoulder Pain	C P Sinus Infections	C P Hemorrhoids
C P Sudden Weight Loss	C P Spinal Curvature	C P Strep Throat	C P Hernia
C P High Blood Pressure	C P Midback Pain	C P Thyroid Problems	C P Liver Problems

Vascular	Pain or Numbness	Skin Problems	Respiratory
C P Nausea/Vomiting	C P Shoulders/Arms	C P Bruise Easily	C P Asthma
C P Dizziness	C P Elbows/Hands	C P Hives or Allergic Reaction	C P Chest Pain
C P Numbness on one side of the face or body	C P Hips/Legs	C P Skin Rash	C P Chronic Cough
	C P Ankles/Knees/Feet	C P Acne	C P Spitting up Blood
C P Difficulty Swallowing			
C P Difficulty Walking	Genito-Urinary	For Women Only	Other
C P Difficulty Speaking	C P Bedwetting	C P Cramps or Backache w/cycle	C P Stroke
C P Fainting/Light Headed	C P Frequent Urination	C P Excessive Menstral Flow	C P Rheum.Fever
C P Double Vision	C P Kidney Infection	C P Irregular Cycles	C HIV/AIDS
C P Rapid Eye Movement	C P Painful Urination	C P Lumps in Breast	C P Alcoholism
C P Neck or Head Pain Like Never Before	C P Prostate Trouble	C P Pain w/intercourse	C P Diabetes
	C P Kidney Stones	C P Pelvic Inflammatory Disease	C P Cancer

Please list any medications you are taking, (including OTC)_____

Please list any medications that you are allergic to: _____

Please list all surgeries and dates_____

_____

Medical Physician's name_____

Your Family History (some health problems are the result of familial tendencies)

Family Member Illnesses Age (or) Age Died ____ Cause of Death_

Father_____

Mother_____

Brother(s)_____

Sister(s)_____

Social History

Do you smoke? Yes No If yes, how may packs per day? _____ For how long?_____

Do you consume alcoholic beverages? Yes No If yes, socially? Moderately? Daily? Rarely?

Do you exercise regularly? Yes No If yes, daily? 3x/week 1x/week Other (specify): _____

In the event of an emergency…

Who should we contact? _____ Relationship: _____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____ X _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office 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 compliance officer 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 compliance officer 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.

Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the Austin Chiropractic Center or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to the Austin Chiropractic Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Austin Chiropractic Center to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: _____ Date: ____/____/____

Printed Name: _____

Consent to Treatment of a Minor Child:

I hereby authorize the doctors of the Austin Chiropractic Center, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent or Legal Guardian: _____Relationship: _____

Date: _____/_____/_____ Witness signature: _____