

Excellence in Health Chiropractic & Rehabilitation Clinic

2008 E. Northern Lights Blvd., Anchorage, AK 99508
(907) 562-6325

Date: _____

Confidential Patient Information

Patients Name: _____ Date of Birth: _____
Address: _____ Chief Complaint: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
SS#: _____ Email: _____
Employer Name and Phone Number: _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes No

Ins. Company: _____ Ins. Phone #: _____
ID#: _____ Group #: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N

Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers _____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds _____ Muscle Relaxers _____ Birth Control _____ Other: _____

Who can we thank for referring you?

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Excellence In Health Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I understand a 12% per annum will be applied to unpaid balances that are over 90 days. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE: September 23, 2015

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclose your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter State or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of law.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment. We may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

Payment. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Health care operations. We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations as permitted by law.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Treatment Alternatives. We may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care. We may, subject to specific limitations, disclose your PHI to friends or family involved in or who help pay for your health care.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.

Appointments, Services and Fundraising. We may contact you to provide appointment reminder, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer. We may contact you to support our fundraising efforts. You may opt-out of receiving any further fundraising communications from our facility by notifying our Privacy Officer at (419) 474-1002, in writing of your name, address, and request to be removed from our fundraising mailing and contact lists.

THE FOLLOWING USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR AUTHORIZATION: (i) uses and disclosures for marketing purposes; (ii) uses and disclosures that constitute the sale of protected health information; (iii) uses and disclosures of psychotherapy notes; and (iv) other uses and disclosures not described in this notice.

SPECIAL USE AND DISCLOSURE SITUATIONS

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting

organizations such as The Joint Commission, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

We may use or disclose your medical information for research purposes but only with your prior authorization or a proper waiver of authorization from an IRB or Privacy Board.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request that we restrict how we use and disclose your health information. These restrictions must be made in writing to our Privacy Officer and signed by you or your representative. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

Access to Individual Health Information. You have the right to inspect and copy your health information. All such requests must be made in writing to our Privacy Officer and signed by you or your representative. We must make PHI available in electronic format upon request and where available. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting within the same twelve-month period. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Notification of Breach. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your PHI.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Officer.

Right to File a Complaint. If you believe that we may have violated your privacy rights, or you disagree with a decision we about access to your PHI, you may file a complaint with the Privacy Officer listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

Right to provide an authorization for other uses and disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Contact: Privacy Officer

If you have questions about this Notice or any complaints about our privacy practices, please contact our privacy officer at 5606 Secor Rd., Toledo, OH 43623 or 419-474-1002.

**A COPY OF THIS NOTICE OF PRIVACY PRACTICES
WILL BE MADE AVAILABLE UPON REQUEST.**

Excellence in Health Chiropractic & Rehabilitation Clinic

2008 E. Northern Lights Blvd., Anchorage, AK 99508

(907) 562-6325

Patient Name: _____

Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Excellence in Health Chiropractic & Rehabilitation Clinic, I am authorizing them to proceed with any treatment that they deem necessary.

Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged \$40

Consent to Evaluate and Treat a Minor:

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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [] No []

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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CASE HISTORY

Name: _____

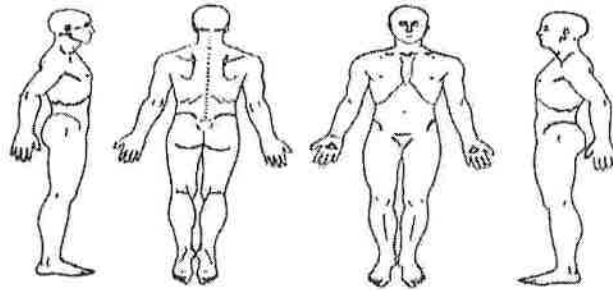
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning -Increase during the day
- afternoon -same all day
- night -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition? Improved Gotten Worse Stayed the same since it began

10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? No Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? No Yes How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? Good Poor Comments _____

15. Is this condition interfering with Work Sleep Daily Routine Recreation

16. List any other major injuries you have had, other than those mentioned above: _____

17. Any other Musculoskeletal problems? No Yes Neurological problems? No Yes

_____ Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____