APPLICATION FOR CARE AT ANCHOR POINT CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to the office? _____

HISTORY of COMPLAINT

Is your pain/complaint the result of a motor vehicle accident? ☐ Yes, ☐ No Or accident at work? ☐ Yes, ☐ No

Please identify your pain/complaint that brought you to this office: _____

On a scale of **0** to **10** with **ten** being the worst pain and **zero** being no pain, rate your pain/complaint by ***circling the number*****:**

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

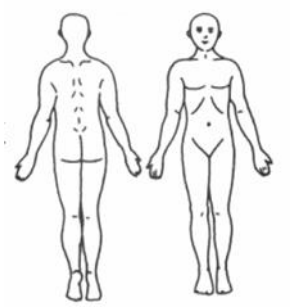
When did the pain/complaint begin? _____When is the pain/complaint at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does your pain/complaint last? ☐ It is constant **OR** ☐ I experience it on and off during the day

How did the pain/complaint happen? _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your pain/complaint

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



In the last 2 weeks has anything made your pain/complaint better? _____

In the last 2 weeks has anything made your pain/complaint worse? _____

Have you seen any doctor or health care practitioner for your primary pain/complaint?

Doctor/Health Care Practitioner's Name: What they did, or prescribed, for you:

_____ | _____

_____ | _____

_____ | _____

Marital Status: ☐ Single ☐ Married

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

What activities are restricted:	**YOUR ACTIVITY LEVEL WHEN NOT IN PAIN**	**YOUR ACTIVITY LEVEL WHEN IN PAIN**
Example: Riding my bike :	Usually 25 miles/5 days a week	Maybe 10 miles/2 days a week
1_____:	_____	_____
2_____:	_____	_____

CONTINUED ON BACK OF PAGE. PLEASE TURN OVER TO CONTINUE.

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY:

1. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Anchor Point Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Anchor Point Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Informed Consent for Chiropractic Services at Anchor Point Chiropractic

I have been informed of the following:

1. That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____
(Guardian of patient under 18)

Witness Signature:_____ Date:_____

ANCHOR POINT CHIROPRACTIC

X-RAY CONSENT

***Who Signs*: MALES AND FEMALES**

The doctor has explained that the purposes of the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I understand that I must then make a determination, to seek additional advice, diagnosis, or treatment for the "unusual finding" from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

_____ DOB: ____ /____ /____

Print Patient Name

_____ DATE: ____ /____ /____

Patient or Authorized person's Signature

CONSENT TO EVALUATE A MINOR CHILD

I, Parent/Legal Guardian, of child, hereby grant permission for my child to receive chiropractic examinations, spinal adjustments and x-rays.

_____ DOB: ____ /____ /____

Print Child's Name

_____ DATE: ____ /____ /____

Parent or Authorized person's Signature

PREGNANCY RELEASE

Who Signs*: FEMALES ONLY -> *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on _____-_____-_____ Date

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ DOB: ____ /____ /____

Print Patient Name

_____ DATE: ____ /____ /____

Patient Signature

Patient Name: _____

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have read below the copy of the HIPAA of 1996 for *Anchor Point Chiropractic.*

Signature_____ Date_____

Our Privacy Pledge

We have and will always protect your privacy. Other than the uses and disclosures described within this notice, we will not sell or provide any of your health information to any outside marketing organization.

Your Right to Receive Confidential Communication

We normally provide information about your health to you in person at the time you receive services. We may also mail you information regarding your health or about the status of your account.

We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy

You have the right to inspect and /or copy your health information for seven years form the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing.

Your Right to Amend

You have the right to request we amend your health information for seven years form the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing with a reason to support the change you are requesting us to make.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to run our practice efficiently and effectively.
4. Your chiropractor and members of the practice staff may need to use your name, address, and phone number and your clinical records to contact you to provide appointment, reminders, information about health alternatives, or other health related information that may be of interest to you. 164.520(b)(l) (iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about health alternatives, or other health related information. If you do not

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give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care. You have the right to inspect or copy the information that we use to contact you to provide appointment reminders or any other health related information at any time.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508.(b)(5)(i).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at our office address.

Other Permitted Uses and Disclosures Without Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2 If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the examples above and in the ***Uses and Disclosures*** section of this notice, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Receive an Accounting of Disclosures made of your Records

You have the right to request an accounting of the disclosures we have made if your health information for the last six years before the date of your request. The accounting will include all disclosures except those disclosures:

1. Required for treatment, to obtain payment for services, or to run our practice.
2. Made to you or those involved in your care.
3. Necessary to maintain a directory of the individuals in our facility.
4. For national security or intelligence purposes, as required by law.
5. Made to correctional officers or law enforcement officers as required by law.
6. That were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within a 12 month period without charge. There will be a fee of $10 for any additional requests during the next 12 months.

Your Right to Limit Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However ,we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in the office for your appointment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Your Right to Complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take actions against you if you do so. While you may make an oral complaint at any time, written comments should be addressed to our Privacy Officer at our office address shown on this document.

To Contact Us

If you would like further information regarding our privacy policies and practices, please contact our office.

This notice is effective the date you first signed the acknowledgement of receipt of this notice. This notice expires seven years after the date upon which your record was created, which is seven years after the last date of service.