

Welcome

Today's Date ____/____/____

Patient Name _____ SS Number ____ - ____ - ____

Name You Prefer To Be Called _____

Birth date ____/____/____ Age ____

Mailing Address _____

City _____ State ____ Zip ____

Home Phone _____ Alt Phone _____

E-Mail Address _____

Status: Minor __ Single __ Married __ Divorced __ Separated __ Widowed __

Spouse Name _____

Referred By: _____

What kind of insurance do you have? _____

Who is the subscriber to the insurance? _____

Relation: _____

What is his/her birthday? ____/____/____

*Don't forget to give us your insurance card so we can make a copy.

In the event of an emergency, who should we contact? _____

Relation _____ Phone number _____

- My insurance policy is a contract between my insurance company and me. This office only bills the insurance for my convenience. If my insurance claim has not been paid within 90 days of billing, the balance automatically becomes my responsibility. I am considered a cash patient until this office has verified my insurance. This office does not process to secondary insurances. This office requires a 24 hour notice for canceling or rescheduling appoints. If you fail to give notice you will be charged accordingly. This office requires that all co pays, cash plans, and deductibles be made before any services are rendered.
- As per HIPAA guidelines, we cannot disclose any information about you without your permission. By signing this form, you agreeing to allow us to use your name in our monthly newsletter welcoming the new patients for the month. I also agree to allow Tuckerton Chiropractic Chiropractic Center to use my picture and diagnosis for advertising purposes.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

____ Adult Patient __ Parent or Guardian __ Spouse

NAME _____

Do you have or ever had any of the following disease or conditions?
(Please circle yes or no)

y/n	Arthritis	y/n	Glaucoma
y/n	Heart Problems	y/n	Alcohol/Drug Abuse
y/n	High/Low Blood Pressure	y/n	Psychiatric problems
y/n	Stroke	y/n	Diabetes
y/n	Severe Headaches	y/n	Kidney problems
y/n	Fainting	y/n	Anemia
y/n	Seizures/ epilepsy	y/n	Cancer
y/n	Breathing or Sinus Problems	y/n	Ulcers/ Colitis
y/n	Asthma	y/n	Immune Diseases
y/n	Artificial Bones	y/n	Shingles
y/n	Artificial joints	y/n	HIV/AIDS

Are you taking any of the following medications?

Heart meds___ Pain Killers (including Aspirin) ___ Muscle relaxers___
Anti-depressants ___ Blood Thinners___ Insulin___ Vitamins___
Others_____

For Women: Are you pregnant? ___How far along are you? ___
Are you nursing? _____

Please list any allergies you may have: _____

Please list any surgeries/treatments with dates _____

Please list any past serious accidents with dates _____

Family health history _____

Do you exercise on a regular basis? _____

Do you smoke? ___ How much? _____ For how long? _____

Have you ever seen a chiropractor before? _____ Who? _____

List any out-of-the-ordinary pains, discomforts, or other symptoms you have or have had recently: _____

Were these symptoms caused by an accident or injury? _____ Date ___/___/___

What have you done to relieve your symptoms? _____

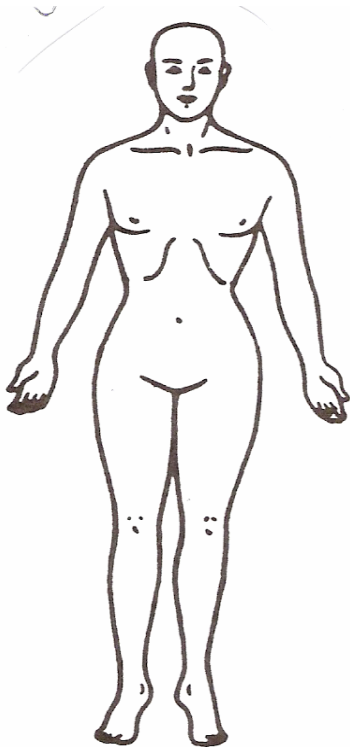
Is this condition getting worse? _____ What makes the pain or discomfort worse? _____

Does it interfere with your daily activities? _____ Which ones? _____

Have you had this or similar in the past? _____ Please explain _____

Have you received any other medical care for this injury? If so, where and what? _____

WHERE DO YOU HAVE PAIN? On the illustrations below, please draw a line from the area of pain or injury to the word which most accurately describes it:



What kind of pain is it?

- Sharp
- Dull
- Tingling
- Numbness

How often do you have it?

- Constant
- Frequent
- Intermittent
- Occasional



On a scale of 1-10 (ten being severe) how would you rate your pain? _____

Signed _____ Date ____/____/____

Patient

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

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Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ **Print:** _____ **Date:** _____