Summit Chiropractic & Rehabilitation

New Patient Registration & History

PATIENT INFORMATION

Name ______________________________________
Last First MI

Street Address ______________________________

____
City State Zip

Home # ______________ Cell _________________

Birthdate ______________ Age ______ Sex: M / F

SS# _________________ Marital Status: S / M / D / W

Spouse Name _________________________________

Who may we thank for referring you________________

IN CASE OF EMERGENCY, CONTACT:

Name ___________________ Relationship _________

Home #_______________ Work # _______________

EMPLOYMENT

Work Status: Employed / Student / Retired / Other _____
Occupation _____________ Employer______________
Address ____________________ Wk# _____________

INSURANCE

Please show insurance card to the front desk

Subscriber's Name_____________________________
Relationship to patient__________________________
Subscriber's Birthdate ___/___/_____ SS#_____________
Ins Carrier _____________________________________
Policy# _____________________ Group# __________

Is patient covered by additional Insurance? Yes / No (circle)
Subscriber's Name_____________________________
Relationship to patient__________________________
Subscriber's Birthdate ___/___/_____ SS#_____________
Ins Carrier _____________________________________
Policy# _____________________ Group# __________

ACCIDENT INFORMATION

Is condition due to an accident? Y / N
Date of Accident _______________

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?
Auto Ins Employer Worker Comp. Other

PAYMENT AND ASSIGNMENT & RELEASE

We require payment in full on your first visit at Summit Chiropractic & Rehabilitation, *PLLC*. (SCR). Payment arrangements may be made in advance, if necessary. All insurance payments received will be credited to your account to cover any existing balance. If your balance is zero we will refund the insurance payment to you. Your insurance policy is a contract between you and your insurance company. If you have any questions about their coverage or amounts paid, you should contact them directly. Any balance you have at our office is your responsibility.

I hereby authorize insurance benefits to be paid directly to SCR. I also authorize SCR to release any information to any insurance company, its representative or any attorney regarding care received at SCR.

I acknowledge that I have read and fully understand the above statements regarding payment policies at SCR. I agree to pay all costs and expenses incurred, including attorney fees, should this account be turned over for collection.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Printed name of Patient, Parent, Guardian or Personal Representative

______________ ______________________
Date **Relationship to Patient**

CURRENT PROBLEM HISTORY

Reason for visit____

When did your symptoms begin? ____

Is this condition getting progressively worse? Y / N / Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): ____ / 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Cramps Tingling Stiffness Swelling Other

How often do you have this pain?_________________________________
Is it constant or does it come-and-go?_____________________________

Does problem interfere with: Work Sleep Daily Routine Recreation
Activities or movements that are painful to perform: Sitting Standing Walking Lying Down

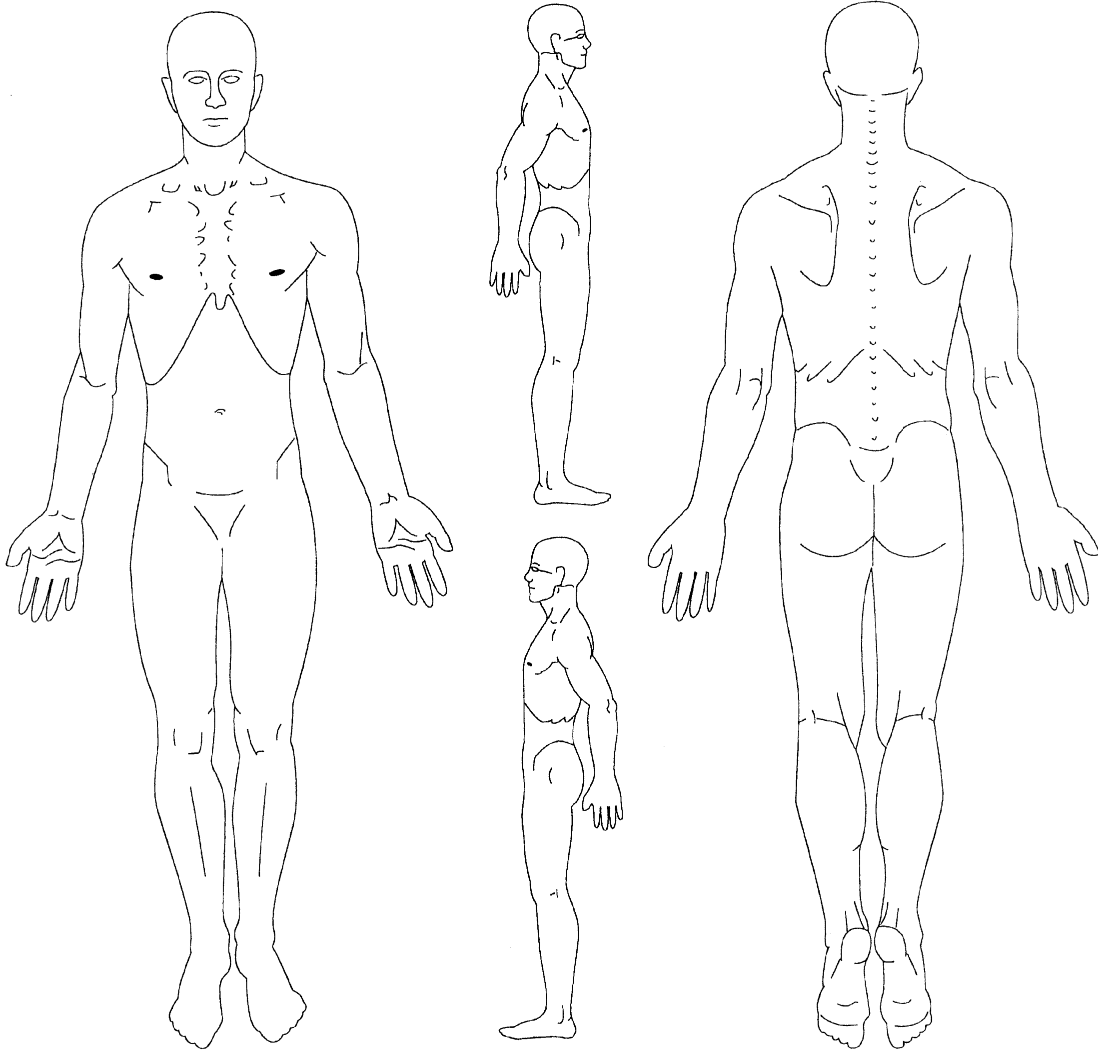
~ OVER ~

Summit Chiropractic & Rehabilitation

Patient Name (Print): ______________________________ Date: ______________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain.

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain that you have right **NOW**:

No Pain Unbearable Pain

Rate your pain at its **BEST** in the past week:

No Pain Unbearable Pain

Rate your **AVERAGE** pain in the past week:

No Pain Unbearable Pain

Rate your **WORST** pain in the past week:

No Pain Unbearable Pain

Summit Chiropractic & Rehabilitation

HEALTH HISTORY

Name________________________________ Date____________

1. What treatment have you already received for your condition? Medications Surgery Physical Therapy
   Chiropractic None Other ____

2. Name & Address of other doctor(s) who have treated you for your condition ________________________________
   ____

3. Date of Last: Physical Exam_______________ Spinal Xray_________________ Blood Test_________________
   Spinal Exam _______________ Chest Xray_________________ Urine Test _________________
   Dental Xray________________ MRI, CT-Scan, Bone Scan ________________________________

4. Place a mark on "Yes" or "No" to indicate you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	Yes	No	Gout	Yes	No	Prostate Problem	Yes	No
Alcoholism	Yes	No	Heart Disease	Yes	No	Prosthesis	Yes	No
Allergy Shots	Yes	No	Hepatitis	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Hernia	Yes	No	Rheum Arthritis	Yes	No
Anorexia	Yes	No	Herniated Disk	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	High Cholesterol	Yes	No	Stroke	Yes	No
Bleeding Disorders	Yes	No	Kidney Disease	Yes	No	Suicide Attempt	Yes	No
Breast Lump	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Bronchitis	Yes	No	Measles	Yes	No	Tonsilitis	Yes	No
Bulimia	Yes	No	Migraines	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Miscarriage	Yes	No	Tumors, Growths	Yes	No
Chemical Dependnt	Yes	No	Mononucleosis	Yes	No	Typhoid Fever	Yes	No
Chicken Pox	Yes	No	Mult Sclerosis	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Mumps	Yes	No	Vaginal Infections	Yes	No
Emphysema	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No	Whooping Cough	Yes	No
Fractures	Yes	No	Parkinson's	Yes	No			
Glaucoma	Yes	No	Pinched Nerve	Yes	No	OTHER____________________		
Goiter	Yes	No	Pneumonia	Yes	No	________________________		
Gonorrhea	Yes	No	Polio	Yes	No	________________________		

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day_______________
Moderate	Standing	Alcohol	Drinks/Wk_______________
Daily	Light Labor	Coffee/Caffeine	Cups/Day________________
Heavy	Heavy Labor	High Stress Level	Reason__________________

INJURIES / SURGERIES	Description	Date
Falls	______________________________	__________
Head Injuries	______________________________	__________
Broken Bones	______________________________	__________
Dislocations	______________________________	__________
Surgeries	______________________________	__________

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
______________________	______________________	______________________
______________________	______________________	______________________
Pharmacy______________	______________________	______________________

Doctor's Use Only – Health Hx Notes

Informed Consent to Treatment

CONSENT TO TREATMENT OF A MINOR CHILD
I authorize the licensed doctor to administer chiropractic care as deemed necessary to my
(Relationship) ________________________________ Name _________________________________

X Parent / Guardian Initials __________

FEMALE PATIENTS
This is to certify that to the best of my knowledge I am not pregnant and that Summit Chiropractic & Rehabilitation has my permission to request x-rays.
Beginning date of your last menstrual period: ______________________
I understand that some herbs may be inappropriate during pregnancy. If I become pregnant, I will inform the doctor.

X Pt. Initials __________

PATIENT'S RIGHTS
Summit Chiropractic & Rehabilitation respects the unique differences of our patient, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patient's behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from his/her physician relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the physician and office staff involved in their care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the physician of available and realistic patient care options.
8. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts.

X Pt. Initials __________

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic manipulation, other procedures and methods of treatment including, but not limited to, various modes of physical therapy, diagnostic x-rays, nutritional therapy, and/or tests by Summit Chiropractic & Rehabilitation and their staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the physician and/or with other clinic personnel the nature and purpose of treatment indicated. I will inform the doctor if I experience any gastro-intestinal upset or allergic reaction to the nutritional supplementation therapy. I understand that results are not guaranteed and I 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 and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for the future conditions for which I seek treatment by this clinic and/or employed staff.

X Pt. Initials __________

SIGNATURE __________________________ Printed Name__________________________ Date____________

WITNESS_____________________________ Printed Name__________________________ Date____________

Summit Chiropractic & Rehabilitation

HIPAA Notice of Privacy Practices

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

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved 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, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information by using a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your appointment time. We may also call you by name in the waiting room when the 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 situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: 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 and 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: The 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 purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

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

You have the right to request to receive a confidential communications from us by alternative means or at an alternative location. You have the right to 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 and 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 you 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 became 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.

Print Name: ____________________________ Signature: _____________________________ Date: _______________