



Welcome!

PATIENT INFORMATION

The doctors and staff of La Plaza Family Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide how we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient at this time, and will refer you to another health care provider, if appropriate.

Patient Identification

Name (First, M, Last), Nickname, Address, Date of Birth, City, State, Zip, Male/Female checkboxes

I authorize La Plaza Family Chiropractic, to contact me using the following methods:

Home Phone, Cell Phone, Work Phone, Email, Mail (checkboxes for Primary/Secondary)

Family Information

Single, Married, Divorced, Widowed checkboxes

Spouse's Name:

Emergency Contact Person: Relationship:

Phone #

How did you hear about us? (check ALL that apply, please)

Patient Referral, Doctor Referral, Insurance Referral, Yellow Pages, Other (checkboxes and text fields)

Office Policies regarding late, cancelled and missed appointments.

In an effort to reduce patient wait-time and improve appointment availability, we have enacted the following policies.

Late Appointment Arrivals

We ask that you provide our office with a courtesy call if you are running late for a scheduled appointment. Our staff will evaluate the day's schedule to determine if you should continue in, or reschedule. If the late arrival is going to have a significant impact on other patient's wait-time, it may be necessary to reschedule you for the next available appointment.

Late Cancellations and Missed Appointments

We ask that you provide our office with as much notice as possible when canceling an appointment. You may incur a \$25.00 fee for missing or canceling your appointment without at least 5 hours notice. We understand that unexpected events and emergencies do occur, and we will always consider this when enforcing this policy. We also encourage you to arrive 5 minutes before your appointment time to allow for signing-in, collecting co-pays, and any other necessary paperwork or updates.

Patient Signature

Date

Name: \_\_\_\_\_  
Date: \_\_\_\_\_

# HEALTH HISTORY

Dr. Pamela Eckmann - Family Chiropractic

1. What brings you to our clinic?  Spinal Check-up  Work Injury  Auto Accident  
 Preventative Health/Nutrition  Fall or Sports Injury  Other: \_\_\_\_\_

**If this is a work injury or an automobile accident, please notify the receptionist NOW.**

What is your main complaint, the reason you are here? \_\_\_\_\_  
\_\_\_\_\_

When did your symptoms start? (DATE) \_\_\_\_\_

How did this start or why do you have this? \_\_\_\_\_

Have you ever been to a doctor of chiropractic before & why?  No  Yes \_\_\_\_\_  
name of doctor

2. How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- Sharp  Shooting
- Dull Ache  Burning
- Numb  Tingling

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None 1 2 3 4 5 6 7 8 9 10 Unbearable

b. How much has pain interfered with your normal work (including both work outside the home and housework)

- Not at all  A little bit  Moderately  Quite a bit  Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(Like visiting with friends, relatives, etc.)

- None of the time  A little of the time  Some of the time  Most of the time  All the time

7. In general would you say your overall health right now is...

- Excellent  Very Good  Good  Fair  Poor

8. Who have you seen for your symptoms?

Other \_\_\_\_\_

- No One  Medical Doctor
- Other Chiropractor  Physical Therapist

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- Xrays Date: \_\_\_\_\_  CT Scan Date: \_\_\_\_\_
- MRI Date: \_\_\_\_\_  Other Date: \_\_\_\_\_

9. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

Other \_\_\_\_\_

- No One  Medical Doctor
- Other Chiropractor  Physical Therapist

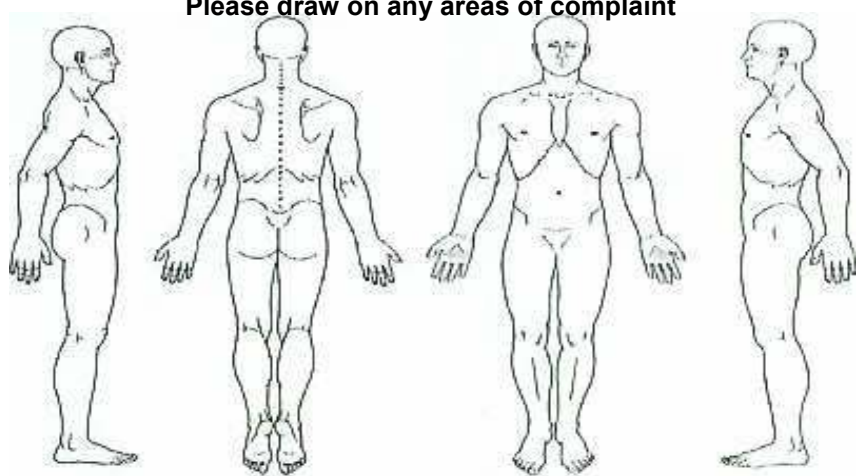
0. Who is your current Primary Care Physician:

Date of last: Physical Exam \_\_\_\_\_

Spinal Exam \_\_\_\_\_

Phone: \_\_\_\_\_

Spinal X-rays \_\_\_\_\_



Please draw on any areas of complaint

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# HEALTH HISTORY

**Dr. Pamela Eckmann - Family Chiropractic**

**1. What is your occupation?**

- Professional/Executive       Laborer       Retired
- a. If you are retired, a homemaker, or a student, what is your current work status?       White collar/Secretarial       Homemaker       FT Student
- Tradesperson       **Other:**

**2. What type of regular exercise do you perform?**

- None       Light       Moderate       Strenuous

**3. What is your height and weight? Height \_\_\_\_\_ Weight \_\_\_\_\_ *Weight at age 20?***

**4. Did you have any childhood diseases?**

- Measles       Mumps       Chicken Pox

**5. Any unusual childhood diseases?**

**6. List any adult illnesses or conditions:** \_\_\_\_\_

**7. List all the surgical procedures you have had and times you have been hospitalized:**

Year: \_\_\_\_\_ Procedure: \_\_\_\_\_

Year: \_\_\_\_\_ Procedure: \_\_\_\_\_

Year: \_\_\_\_\_ Procedure: \_\_\_\_\_

Year: \_\_\_\_\_ Procedure: \_\_\_\_\_

Year: \_\_\_\_\_ Procedure: \_\_\_\_\_

**8. For each of the conditions listed below, place a check in the *Past* column if you have had the condition in the past, *EVER*.**

**If you presently have a condition listed below, place a check in the *Present* column.**

	<i>Past</i>	<i>Present</i>		<i>Past</i>	<i>Present</i>		<i>Past</i>	<i>Present</i>
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Use Tobacco Products
						<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones			
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
			<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain				<input type="checkbox"/>	<input type="checkbox"/>	Herpes Zoster
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
			<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			<b>Females Only</b>
			<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills/Patch/Shot
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis				<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances				<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
			<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome			

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# HEALTH HISTORY

Dr. Pamela Eckmann - Family Chiropractic

**List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:**

Medication Name	Reason	Nutritional/Herbal Sups	Reason

**2. Please indicate your social habits:**

- a. Sodas \_\_\_\_\_ per day      \_\_\_\_\_ per week       Regular     De-Caffeinated     Diet
- b. Coffee \_\_\_\_\_ per day      \_\_\_\_\_ per week       Regular     De-Caffeinated
- c. Smoke \_\_\_\_\_ per day      \_\_\_\_\_ per week      How many years? \_\_\_\_\_
- d. Sleep \_\_\_\_\_ hours per night       Rested       Interrupted       Poor
- e. Sleeping Position     Left Side     Right Side     Back     Stomach
- f. Exercise       Walk/Run     Weights       Pilates     Cardio Machines
- None       Yoga       Belong to a gym/workout center
- g. Self-manipulation     Neck       Back       Knuckles     Never
- h. Dietary Habits       None       Vegetarian       Low Carb     \_\_\_\_\_
- i. Blood Type       A +      -     B +      -       AB +S-     O +      -

**3. Indicate if an immediate family member has had any of the following:**

- Rheumatoid Arthritis       Diabetes       Scoliosis       Spinal Problems
- Heart Problems       Cancer       Lupus       Immune Problems
- Stroke       Thyroid       Other: \_\_\_\_\_
- Alzheimer's       Parkinson's

**4. Describe your daily work habits:**

- Mostly Computer, Desk, Phones and Sitting
- Home Computer, Desk, Sitting and Some Moving Around-such as teaching
- Home Computer, Desk Sitting and Some Travel (car or plane) such as in Sales
- Mostly Light Manual Labor - lifting, stocking, on feet all day and such
- Mostly Heavy Manual Labor - Lifting & moving heavy objects, digging, construction, etc.
- Housework, kids, gardening - mostly home activities

**5. Is there anything else you'd like the doctor to know?** \_\_\_\_\_

**6. What do you hope to get from you visit/treatment (select all that apply)?**

- Reduce symptoms       Explanation of condition/treatment       How to prevent this from occurring again
- Resume/Increase activity     Learn how to take care of this on own

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Doctor's Additional Comments:**

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**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ Page 3

# Back Index

ACN Group, Inc. Form BI-100

ACNGroup, Inc. Use Only rev3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one Section apply, please mark the one statement that most closely describes your problem.

## **Pain Intensity**

- ① The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## **Sleeping**

- ① I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## **Sitting**

- ① I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## **Standing**

- ① I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## **Walking**

- ① I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## **Personal Care**

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- ① I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## **Traveling**

- ① I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## **Social Life**

- ① My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## **Changing degree of pain**

- ① My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NI-100

ACNGroup,Inc.UseOnly rev3/27/2003

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

## **Pain Intensity**

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score



## CONSENT TO SERVICES

Patient Name: \_\_\_\_\_

File Number: \_\_\_\_\_

*Alicia Castello, D.C. Pamela Eckmann, D.C.*

### Consent to Chiropractic Services

#### EXPLANATION OF RISKS

Manipulation is considered one of the safest methods available for the treatment of many spinal and joint disorders. Every reasonable precaution is taken to reduce the risk of adverse effects for this and any treatment. However, as with any health care procedure, there are certain complications which may arise during a manipulative adjustment. Those complications include but are not limited to: (1) Temporary aggravation of symptoms; (2) Other unlikely, but possible complications being stretch injuries to muscles, tendons and soft tissue, fracture or displacement of bones, disc injuries, injuries to nerves and occlusion of the blood vessels. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Please note the exact incidence of serious complication is described as rare or very rare.

I hereby consent to the performance of chiropractic procedures and diagnostics that the doctor of chiropractic may consider necessary or advisable in the course of my health care. I have read and understand the explanation of risks, and I acknowledge that no guarantees have been made to me concerning the result of treatment.

Initials: \_\_\_\_\_

### Consent to Treatment of a Minor Child

I authorize the licensed chiropractor, and whomever she may designate as assistants to perform diagnostic tests, including x-rays if needed, and administer treatment to my \_\_\_\_\_ (relationship), \_\_\_\_\_ (name).

Initials: \_\_\_\_\_

### Female Patients Only

This is to certify that to the best of my knowledge, I am NOT pregnant and that La Plaza Family Chiropractic has permission to take X-rays. Ten days following the onset of a menstrual period are generally considered to be safe for an X-ray exam. My last menstrual period began on \_\_\_\_\_. I understand that if I am pregnant and have X-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus. Please check one of the following:

- I am NOT pregnant       I could be pregnant       I AM pregnant

Initials: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(or legal guardian)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of La Plaza Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I \_\_\_\_\_, [patient's name] , authorize La Plaza Family Chiropractic to release my Protected Health Information to the following individuals: (Please include any family members or friends that you would like your medical records, tests, or other health related information to be released to.)

\_\_\_\_\_  
Name of Recipient

\_\_\_\_\_  
relationship

\_\_\_\_\_  
Name of Recipient

\_\_\_\_\_  
relationship

\_\_\_\_\_  
Name of Recipient

\_\_\_\_\_  
relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

**EXPIRATION DATE:** This Authorization is valid until \_\_\_\_\_.

## FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

Patient Unavailable

Patient Physically Unable

Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

Personally

Mail

Phone Follow Up

Other: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name of Physician

La Plaza Family Chiropractic