

# Chiropractic Registration and History

## Patient Information

Date: \_\_\_\_\_  
SS#: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Suite / Apt#: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_  
Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:            Male            Female

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

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

Spouse's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## In case of Emergency, contact:

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

Relationship: \_\_\_\_\_

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

## Accident Information

Is your condition do to an accident: Yes No

Date of Accident: \_\_\_\_\_

Type: Auto \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

To whom have you made a report of your accident?

\_\_\_\_\_ Auto Ins. \_\_\_\_\_ Employer \_\_\_\_\_ Work Comp.

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

\*Please find additional documents under patient forms to complete if this is a result of an auto accident.



## Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. French all insurance benefits, if any, otherwise payable to me for my services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relating services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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

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

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

Relationship to Patient: \_\_\_\_\_

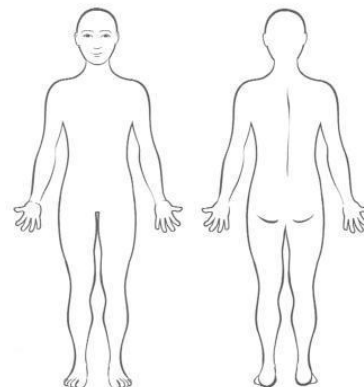
## Patient Condition:

Reason for Visit: \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse: Yes No

Mark an **X** on the picture below where you continue to have pain, numbness, or tingling.



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## Patient Condition Continued:

Rate the severity of your pain on a scale from 1 (least pain) to 10 (Sever pain). \_\_\_\_\_

Type of pain: (Circle all that apply)

Sharp	Dull	Throbbing
Aching	Shooting	Numbness
Burning	Tingling	Cramps
Stiffness	Swelling	Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does the pain interfere with your:

Work - Sleep - Daily Routine - Recreation

Activities or movements that are painful to perform:

Sitting – Standing – Walking – Bending – Lying Down

## Health History

What treatments have you already received for your condition? Medication – Surgery – Physical Therapy

Name of Doctors who have treated you for your condition? \_\_\_\_\_

**Date of last:** Physical Exam: \_\_\_\_\_  
Spinal X-Ray: \_\_\_\_\_  
Blood Test: \_\_\_\_\_  
Dental X-Ray: \_\_\_\_\_  
MRI, CT, Bone Scan: \_\_\_\_\_

### Exercise:

\_\_\_\_\_ None  
\_\_\_\_\_ Moderate  
\_\_\_\_\_ Daily  
\_\_\_\_\_ Heavy

### Work Activity:

\_\_\_\_\_ Sitting  
\_\_\_\_\_ Standing  
\_\_\_\_\_ Light Labor  
\_\_\_\_\_ Heavy Labor

### Habits:

\_\_\_\_\_ Smoking Packs/Day \_\_\_\_\_  
\_\_\_\_\_ Alcohol Drinks/Week \_\_\_\_\_  
\_\_\_\_\_ Coffee/Caffeine Cups/Day \_\_\_\_\_  
\_\_\_\_\_ High Stress Level Reason \_\_\_\_\_

Are you pregnant? Yes No Due Date: \_\_\_\_\_

Please check to indicate if you have had any of the following:

_____ AIDS/HIV	_____ Alcoholism
_____ Allergy Shots	_____ Anemia
_____ Anorexia	_____ Appendicitis
_____ Asthma	_____ Bleeding Disorder
_____ Breast Lump	_____ Bronchitis
_____ Bulimia	_____ Cancer
_____ Cataracts	_____ Chemical Dependency
_____ Chicken Pox	_____ Diabetes
_____ Emphysema	_____ Epilepsy
_____ Fractures	_____ Glaucoma
_____ Gout	_____ Heart Disease
_____ Hepatitis	_____ Hernia
_____ High Blood	_____ High Cholesterol
_____ Pressure	_____ Migraine / Headaches
_____ Measles	_____ Liver Disease
_____ Miscarriages	_____ Mononucleosis
_____ Mumps	_____ Multiple Sclerosis
_____ Osteoporosis	_____ Pacemaker
_____ Pinched Nerve	_____ Parkinson's disease
_____ Pneumonia	_____ Polio
_____ Prosthesis	_____ Prostate Problem
_____ Scarlet Fever	_____ Psychiatric Care
_____ Stroke	_____ Rheumatic Fever
_____ Tuberculosis	_____ Suicide Attempt
_____ Tonsillitis	_____ Thyroid Problems
_____ Ulcers	_____ Tumor, Growths
_____ Typhoid Problems	_____ Herniated Disk
_____ Vaginal Infections	_____ Whooping Cough
_____ Kidney Disorder	_____ Rheumatoid Arthritis
_____ Sexually Transmitted Disease	
_____ Other: _____	

Injuries/Surgeries you have had: \_\_\_\_\_

Falls: \_\_\_\_\_ Broken Bones: \_\_\_\_\_

Head Injury: \_\_\_\_\_ Dislocations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Vitamins/Herbs/Minerals: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**  
**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU**  
**MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO**  
**THAT INFORMATION**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

**NO CONSENT REQUIRED**

The Practice may use and/or disclose your PHI for the purposes of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

- (a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- (c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care
- (d) Emergency Situations -
  - (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
  - (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

- (g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm
- (h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
- (i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
- (j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
- (k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- (l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- (m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
- (n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- (o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

**APPOINTMENT REMINDER** - The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

**SIGN-IN LOG** - The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

**FAMILY/FRIENDS** - The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

**AUTHORIZATION** - Uses and/or disclosures, other than those described above, will be made only with your written authorization.

## **YOUR RIGHTS**

1. You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time and to request a revocation, you must submit a written request to the Practice's COMPLIANCE OFFICER.
- (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law, however, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's COMPLIANCE OFFICER. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will

comply with your request unless the information is needed in order to provide you with emergency treatment

(c) Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the Practice's COMPLIANCE OFFICER. The Practice will accommodate all reasonable requests.

- (d) Inspect and obtain a copy your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the Practice's COMPLIANCE OFFICER. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request
- (e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's COMPLIANCE OFFICER. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- (f) Receive an accounting of disclosures of your PHI as provided by law. The request should indicate in what form you want the list (such as a paper or electronic copy)
- (g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's COMPLIANCE OFFICER.
- (h) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202/619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850/414-3300, if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's COMPLIANCE OFFICER. All complaints must be in writing.
- (i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's COMPLIANCE OFFICER, Geri Underhill, at (239) 598-2244 or via email at wellbilling@embarqmail.com.

## **PRACTICE'S REQUIREMENTS**

### **1. The Practice:**

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:
  - Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases and Section 456.057 relating to patient records ownership, control and disclosure.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

## **QUESTIONS AND COMPLAINTS**

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact person appointed for this practice. The COMPLIANCE OFFICER is Geri Underhill.

You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the COMPLIANCE OFFICER. We will not retaliate against you in any way if you file a complaint.

## **EFFECTIVE DATE**

This Notice is in effect as of 11/23/2010.

# ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

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Patient Name (Please Print)

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Date

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Parent, Guardian or Patient's Legal Representative

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Signature

This form will be placed in the patient's chart and maintained for six years.