WELCOME TO OUR OFFICE

Name_____**Today's Date**_____

Address_____**City**_____**Zip**_____

Phone numbers Home _____**Cell**_____**Work** _____

SSN_____**Sex M F Birthdate** ____/____/____ **Marital Status M S W D**

Emergency Contact _____ **Phone Number** _____

Employer_____

E-mail Address_____ **Hobbies** _____

Insured's Name (if different from patient) _____**DOB**_____

How did you hear about our office: Internet Health Talk Physician Attorney Friend

Who referred you to the office _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand West Jefferson Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to West Jefferson Chiropractic as payment for professional services rendered. However, I clearly understand and agree that I am personally responsible for payment.

Signed _____Date _____

CONSENT FOR TREATMENT

I understand by signing below I am giving the doctors at West Jefferson Chiropractic consent to examine and provide treatment that the doctor believes is in my best interest. I am aware that any risks regarding care will be explained.

Signed _____ Date _____

PRIVACY NOTICE.

I am aware that West Jefferson Chiropractic is protecting my **PRIVATE** medical records in compliance with **HIPAA** guidelines. I understand that my information will be used for intra-office procedures and may be shared with other healthcare providers (with my permission) for the benefit of my healthcare. My records cannot be released without my written permission. The one-time written request is good for any subsequent request for records. I may revoke the permission for release of records in writing. I also understand that I may file a formal complaint with the privacy officer about any possible violations or these policies and procedures. I will let the office know if there is anyone that I DO NOT want to see my records. By signing below I acknowledge that I have received a written copy of the office's privacy policies

Signed _____ Date_____

Family Physician_____

Current Medications_____

_____

Other Physicians _____

Previous Surgeries _____

Allergies _____

Vitamins / Supplements / Herbs _____

_____

Please check any health complaints you are currently experiencing.

___ Headache	___ Foot Problems	___ Ear Infections
___ Migraine	___ Difficulty Sleeping	___ Frequent Colds / Infections
___ Ringing in Ears	___ Fingers Go to Sleep	___ Digestive Problems
___ Dizziness	___ Arm / Hand Pain / Numbness	___ High / Low Blood Pressure
___ Neck Pain	___ Leg Pain / Numbness	___ Stress
___ Mid Back Pain	___ Carpal Tunnel Syndrome	___ Nervousness
___ Low Back Pain	___ Asthma / Allergies	___ Depression / Anxiety
___ Hip Pain R L	___ Weight Gain / Loss	___ Tension
___ Knee Pain R L	___ Sinus Problems	___ Fatigue

Other_____

How would you rate your overall health? Excellent Good Fair Poor

Are you interested in improving your overall health? Yes No

PAST MEDICAL HISTORY

Have you ever had any of the following

Cancer	Y N	Liver Disease	Y N	Thyroid Disease	Y N
Kidney Disease	Y N	Diabetes	Y N	Heart Disease	Y N
Stroke	Y N	Hi Blood Pressure	Y N	Epilepsy	Y N

Other _____

Any Family Members have any of the above? Please list _____

_____

SOCIAL HISTORY

Tobacco	Y	N	ppd___yrs___
Alcohol	Y	N	drinks/ wk
Caffeine	Y	N	cups/day
Illegal drugs	Y	N	

Type:_____

FOR WOMEN ONLY

Are you Pregnant	Y	N
Menstrual pain	Y	N
Irregularity	Y	N

Birth control _____ (type)

Hysterectomy	Y	N
Ovaries present	Y	N
Hot Flashes	Y	N

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.

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with us."
"It is our policy to provide a substitute health care provider, authorized by us to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.
In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
We reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us.

Complaints
Complaints about your Privacy rights, or how we have handled your health information should be directed to us within 5 working days.

Our privacy manager is Dr. Michael Monroe. All concerns should be addressed to him

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

Please sign below to acknowledge you have received our Notice of Privacy Practices and your Privacy Rights.

_____ _____

Signature Date