



37339 Green Street  
New Baltimore, MI 48047  
586-725-1111

4040 24<sup>th</sup> Avenue  
Fort Gratiot, MI 48059  
810-385-0235

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

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Preferred Contact#:  Home  Work  Cell Referred By: \_\_\_\_\_

Marital Status:  Single  Divorced  Widowed  Married To: \_\_\_\_\_ # of Children: \_\_\_\_\_

Children's Names & Ages: \_\_\_\_\_

Full-Time Employment  Part-Time Employment  Self-Employed  Unemployed  Retired

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

Full-Time Student  Part-Time Student School Name: \_\_\_\_\_

**What is the primary reason for your visit?** \_\_\_\_\_

If your complaints include pain, how would you describe it? \_\_\_\_\_

Aching  Burning  Dull  Sharp  Shooting  Stabbing  Throbbing  Other: \_\_\_\_\_

Is this due to a:  Automobile Accident  Work-Related Injury  Personal Injury Case  None

When did your pains/symptoms begin (include date if possible)? \_\_\_\_\_

On a scale of 0 to 10, how would you rate your pain/symptoms today? (Please circle a number below)

None = 0    1    2    3    4    5    6    7    8    9    10 = Worst Possible

Have you had recent treatment for this condition?  No  Yes - Please List: \_\_\_\_\_

Since your symptoms began, have you noticed any function changes:  Bowel  Bladder  Sexual  None

WOMEN ONLY: To your knowledge, are you pregnant?  No  Yes - Due Date: \_\_\_\_\_

Have you ever been to a doctor of chiropractic before?  No  Yes - How long ago? \_\_\_\_\_

Name of previous Chiropractor: \_\_\_\_\_

Do you see a Medical Doctor or an Osteopath?  No  Yes - Date of last visit? \_\_\_\_\_

Name of Medical Doctor/Osteopath: \_\_\_\_\_

= NOW HAVE     = IN PAST YEAR

- |  |  |  |  |
|--|--|--|--|
| <input type="radio"/> Allergies              | <input type="radio"/> Hay Fever                    | <input type="radio"/> Sinus Trouble                  | <input type="radio"/> Asthma                       |
| <input type="radio"/> Difficulty Speaking    | <input type="radio"/> Menstrual Problems or Pain   | <input type="radio"/> Prostate Trouble               | <input type="radio"/> Erectile Dysfunction         |
| <input type="radio"/> Fatigue or Weakness    | <input type="radio"/> Night Sweats                 | <input type="radio"/> Wheezing                       | <input type="radio"/> Fertility Problems           |
| <input type="radio"/> Unexpected Weight Loss | <input type="radio"/> Chronic Cough                | <input type="radio"/> Excessive Thirst               | <input type="radio"/> Unexpected Weight Gain       |
| <input type="radio"/> Shortness of Breath    | <input type="radio"/> Thyroid Trouble              | <input type="radio"/> Sleeping Problems              | <input type="radio"/> Chest Pain or Pressure       |
| <input type="radio"/> Anxiety or Nervousness | <input type="radio"/> Skin Problems                | <input type="radio"/> Heart Trouble                  | <input type="radio"/> Mood Swings or Irritability  |
| <input type="radio"/> Loss of Balance        | <input type="radio"/> High Blood Pressure          | <input type="radio"/> Mental or Emotional Difficulty | <input type="radio"/> Dizziness or Lightheadedness |
| <input type="radio"/> Low Blood Pressure     | <input type="radio"/> Depression                   | <input type="radio"/> Vertigo                        | <input type="radio"/> Cold Hands or Feet           |
| <input type="radio"/> Arthritis              | <input type="radio"/> Fainting                     | <input type="radio"/> Abdominal Pain                 | <input type="radio"/> Bone Fracture                |
| <input type="radio"/> Headaches              | <input type="radio"/> Indigestion or Upset Stomach | <input type="radio"/> Dislocated Joints              | <input type="radio"/> Seizures                     |
| <input type="radio"/> Excess Gas             | <input type="radio"/> Autoimmune Disease           | <input type="radio"/> Loss of Memory                 | <input type="radio"/> Heartburn                    |
| <input type="radio"/> Cancer                 | <input type="radio"/> Vision Trouble               | <input type="radio"/> Constipation                   | <input type="radio"/> Diabetes                     |
| <input type="radio"/> Hearing Trouble        | <input type="radio"/> Diarrhea                     | <input type="radio"/> Fibromyalgia                   | <input type="radio"/> Ear Infections               |
| <input type="radio"/> Nausea or Vomiting     | <input type="radio"/> Multiple Sclerosis           | <input type="radio"/> Ringing or Buzzing in Ears     | <input type="radio"/> Bedwetting                   |
| <input type="radio"/> Rheumatic Fever        | <input type="radio"/> Loss of Smell                | <input type="radio"/> Kidney or Bladder Trouble      | <input type="radio"/> Other: _____                 |
| <input type="radio"/> Difficulty Swallowing  | <input type="radio"/> Blood in Urine or Stool      | <input type="radio"/> <b>No Conditions/Illnesses</b> |  |

Do you exercise?  No  Yes – How often? \_\_\_\_\_

Do you have weight issues?  No  Yes – Condition: \_\_\_\_\_

Are you currently taking any vitamins or nutritional supplements?  No  Yes

Do you sleep on your stomach?  No  Yes

Do you carry your wallet in your back pocket?  No  Yes

Do you have any scars from injuries or surgeries?  No  Yes

Have you ever had spinal taps or injections?  No  Yes – When? \_\_\_\_\_

Have you ever been knocked unconscious?  No  Yes – When? \_\_\_\_\_

Have you ever had a lapse in memory?  No  Yes – When? \_\_\_\_\_

Do you suffer from any other medical conditions other than what you are now consulting us for?  No  Yes

Accidents (Automobile, Work-Related, Personal Injury, Slip & Fall or any other serious injury):  No  Yes

Prior illnesses (other than colds and flu):  No  Yes \_\_\_\_\_

Surgeries and/or hospitalizations:  No  Yes \_\_\_\_\_

Are you currently taking ANY over the counter medication?  No  Yes – List and indicate for what condition:

Drug: \_\_\_\_\_ Condition: \_\_\_\_\_ Drug: \_\_\_\_\_ Condition: \_\_\_\_\_

Drug: \_\_\_\_\_ Condition: \_\_\_\_\_ Drug: \_\_\_\_\_ Condition: \_\_\_\_\_

## AGREEMENT

I understand that all services are to be paid in full on the day of service unless other arrangements have been agreed upon in writing. If your insurance is billed out and for any reason they don't pay, you are responsible for your payment.

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

I authorize the release of any medical information necessary.

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

I authorize payment of medical benefits to the Bend Chiropractic Clinic, PC.

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

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and/or your spouse checked for subluxations, check the box below and they will receive a complimentary consultation within 2 weeks of your starting care. This consult is at no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care.

**I would like my family members to get checked for subluxations within the next 2 weeks!**



Bend Chiropractic  
37339 Green St New Baltimore MI 48047  
586 725 1111

Bend Chiropractic  
4040 24th Avenue Fort Gratiot MI 48059  
810 385 0235

## HIPAA NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

### POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

### USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- **Care** – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services you received from the Practice so the Practice may be properly reimbursed.
- **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 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.

Note: Genetic information is protected by law and is not considered part of Health Care Operations.

- **Fundraising** – To the extent that the Practice engages in fundraising activities (i.e. appeals for money, help, or event sponsorships), certain types of PHI may be disclosed for these purposes, unless you specifically 'opt out' of receiving notification. To 'opt out', call or email the Practice to be excluded from fundraising campaigns.

### AUTHORIZATION NOT REQUIRED

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

1. **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. **Business Associate** – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.
3. **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. 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 the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. Family and Friends - Unless expressly prohibited by you, the Practice may disclose PHI to a member of your family, a relative, a close friend or any other person you identify, as it *directly* relates to that person's involvement in your health care. If you do not express an objection or are unable to object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.
9. 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.
10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.
11. 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, or to a funeral director as permitted by law and as necessary to carry out its duties.
12. 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.
13. 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 such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed. Individuals have the option to 'opt out' of certain types of research activities.
14. 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.
15. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.
16. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.
17. 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.
18. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.
19. Marketing - Face to face communication directly with the patient, treatment and coordination of care activities, refill reminders or communications about drugs that have already been prescribed, or promotional gifts of nominal value do not require authorization as long as the Practice receives no financial remuneration for making the communication. All other situations require separate authorization.
20. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

## **AUTHORIZATION**

Uses and/or disclosures, other than those described above, will be made only with your *written* Authorization. These authorizations may be revoked at any time, however, we cannot take back disclosures already made with your permission.

We also will NOT use or disclose your PHI for the following purposes, where applicable, without your express *written* Authorization:

- Marketing - This does not including marketing communications described in item #19. The Practice will obtain prior authorization before disclosing PHI in connection with marketing activities in which financial remuneration is received.
- Sales - The Practice may receive payment for sharing your information in specific situations (i.e. public health purposes or specific research projects - see #12 above).
- Specially protected information - Certain types of information such as psychotherapy notes, HIV status, substance abuse, mental health, and genetic testing information require their separate written authorization for the purposes of treatment, payment or healthcare operations.

## **APPOINTMENT REMINDER**

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

## **TREATMENT ALTERNATIVES/BENEFITS**

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you.

## **YOUR RIGHTS**

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Marketing revocations may be submitted to the Practice via telephone or email.
- 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 Privacy 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.
- Restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Practice.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee (to cover costs incurred by the Practice to reproduce records) for the cost of copying, mailing or other supplies associated with your request.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy 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 originating 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 have the right to submit a written statement of disagreement.
- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in

what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

- Receive a paper copy of this Notice of Privacy Practices from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing. If your complaint is not satisfactorily resolved, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address upon request.
- To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer.

### **PRACTICE'S REQUIREMENTS**

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices upon request.
- Is required to abide by the terms of this Notice of Privacy Practices.
- Reserves the right to change the terms of this Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all of your PHI that it maintains.
- Will not retaliate against you for making a complaint.
- Must make a good faith effort to obtain from you an Acknowledgment of receipt of this Notice.
- Will post this Notice of Privacy Practices in its lobby and on the Practice's web site, if the Practice maintains a Web site.
- Will inform you in a timely manner, if there is a case of a breach of unsecured health information.

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.

Our Privacy Contact is Kristine Angers. You may contact our Privacy Officer, or any staff member, including your Doctor of Chiropractic at (586)725-1111.

This notice was published and becomes effect January 1, 2014.