Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

These forms are provided as a service to subscribers to HIPAAps, and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in you locale.

Date_____ Referred by _____

Cell phone _____

Name _____Home phone _____

Last *First* *Middle* Email_____

Address _____ City/ State/ Zip _____

DOB _____Sex _____ SS# _____ Marital Status M S D W

Contact Friend/ Relative _____ Phone _____

Address _____ City/ State/ Zip _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ Position _____

Spouse's Name _____ Phone _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ DOB _____

Primary Care Provider _____ Phone _____

PLEASE READ & SIGN

Failure to cancel appointments without 24-hour notice will result in full appointment fee.

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

Signature *Date*

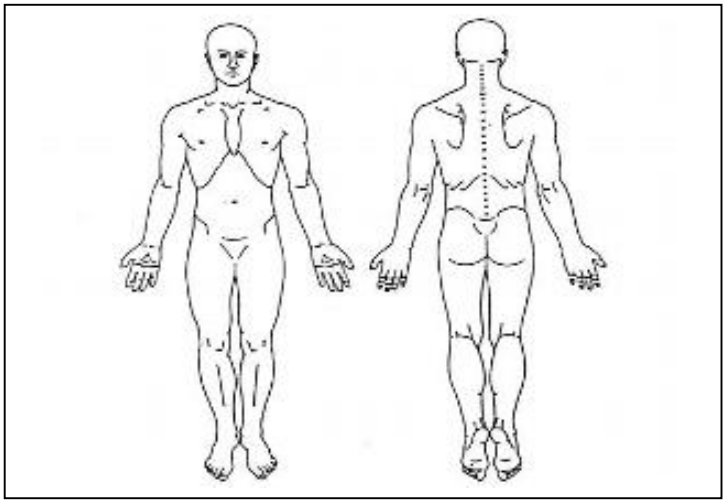
NAME_____DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

NAME _____ Date _____

PERSONAL HISTORY

Mark the box with an X if it applies to you & circle the appropriate symptom. Explain all YES answers with dates (month & year).

Has any blood relative ever had:

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems
- ☐ Cancer
- ☐ Hypoglycemia

Have you ever had problems with:

- ☐ Weight Change, gained or lost in past 5 years
- ☐ Fever, chills, sweats
- ☐ Allergy, Aslhma
- ☐ Anemia, Bleeding or bruising
- ☐ Thyroid Problems, Heat or cold intolerance
- ☐ Diabetes
- ☐ Eye problems (glasses, glaucoma etc.)
- ☐ Ear problems (ringing, deafness, ear infections)
- ☐ Nose/Throat problems (sinis, nosebleeds, hoarseness)
- ☐ Dizziness
- ☐ Jaw (TMJ) or dental problems
- ☐ Nausea or Vomiting
- ☐ Stomach Problems (ulcer, indigestion, heartburn, Hiatal hernia)
- ☐ Abdominal pain or swelling
- ☐ Diarrhea or constipation

How often do you have a bowel movement?

- ☐ Tarry black stool or blood in stool
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Liver or Gall Bladder problems
- ☐ Pancreas
- ☐ Do you drink alcohol?

How much?

- ☐ Shortness of breath, wheezing
- ☐ Lung problems (coughing, phlegm blood, infection, pneumonia) Tuberculosis?
- ☐ Do you smoke? How many years? How many packs?
- ☐ Occupational or Environmental Inhalation
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations in the heart
- ☐ High Blood Pressure
- ☐ Rheumatic fever

NAME _____ Date _____

- [ ] Urinary problems (Frequent, painful, or dribbling urination)
- [ ] Blood in Urine
- [ ] Bladder or Kidney problems
- [ ] Sexually transmitted diseases
- [ ] Testicle mass or pain
- [ ] Breast lump, pain or nipplc discharge

FOR FEMALES:

- [ ] Menstral problems
- [ ] Pelvic pain, vaginal discharge
- [ ] Ovarian cyst
- [ ] Menopause , At what age?

Menstrual flow: How many days? How many days between periods?
Date of last period
Date of last PAP?

- [ ] Skin itching or rash
- [ ] Skin Cancer
- [ ] Headaches
- [ ] Seizures
- [ ] Head trauma
- [ ] Stroke
- [ ] Joint pain, swelling or stiffness
- [ ] Neck Pain
- [ ] Upper back pain
- [ ] Low back pain
- [ ] Arm or leg problems
- [ ] Fractures, dislocations, or sprains
- [ ] Car accidents, falls or injuries
- [ ] Drug abuse
- [ ] Pyschiatric problems, anxiety, depression
- [ ] Shoe lift or insert
- [ ] Poor sleep quality. How many hours per night?

List all hospitalizations, surgeries, diseases with date:

List current medications & vitamins/supplements:

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month**.
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely. We are participating providers for most insurance companies including Cigna, Aetna, Emerald, Medical Mutual, United Healthcare, Humana, PHCS and Medicare, we are not participating in any HMOs. Most insurance companies cover chiropractic, however deductibles and co-pays do vary.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____

PERSONAL INJURY QUESTIONNAIRE

Name_____ Phone ( )_____

Address_____ City_____ State_____ Zip_____

Age_____ Birthday_____ Sex_____ S/S #_____

Employer's Name_____ Employer's Address_____

Your Ins. Co._____ Policy #_____Agent's Name_____

Name on Policy (If other than self)_____ Policy #_____

Responsible Party's Name_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name_____ Policy #_____

ATTORNEY

Name_____ Phone ( )_____

Address_____ City_____ State_____ Zip_____

Were there any witnesses? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT:

1. Date of Accident_____ Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( )Back Seat
3. Number of people in you vehicle?_____ Were you wearing seat belts?_____
4. What direction were you headed?( ) North ( ) East ( )South ( ) West
   on (name of street)_____
5. What direction was other vehicle headed?( ) North ( ) East ( ) South ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____
    _____
    _____
    _____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, please describe in detail:_____
    _____
    _____
    _____
    _____

12. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

13. What are your PRESENT complaints and symptoms?_____
    _____
    _____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
    If yes, please describe:_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received._____
    _____
    _____

17. Where were you taken after the accident?_____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address:_____
    _____
    What type of treatment did you receive?_____
    _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

□Headache	□Irritability	□Numbness in Toes	□Face Flushed	□Feet Cold
□Neck Pain	□Chest Pain	□Shortness of Breath	□Buzzing in Ears	□Hands Cold
□Neck Stiff	□Dizziness	□Fatigue	□Loss of Balance	□Stomach Upset
□Depression	□Fainting	□Head Seems Too Heavy	□Sleeping Problems	□Constipation
□Back Pain	□Loss of Smell	□Pins & Needles in Arms	□Lights Bother Eyes	□Cold Sweats
□Nervousness	□Loss of Taste	□Pins & Needles in Legs	□Loss of Memory	□Fever
□Tension	□Ears Ring	□Numbness in Fingers	□Diarrhea	□ _____

    Symptoms Other Than Above_____

21. Have you lost time from work as a result of this accident? ( )Yes ( ) No If yes, describe:
    a. Last Day Worked:_____
    b. Type of Employment:_____
    c. Present Salary:_____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compenstation:_____

22. Do you notice any activity restrictions as result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:_____

_____

_____

_____

23. Other pertinent information:_____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE