Ploucha | Chiropractic Center

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

PATIENT NAME

_____

DATE COMPLETED

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: _____ /_____ /_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

Have you been treated for this? ❑ Yes ❑ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what? _____ How long were you treated? _____ Last treatment: _____ /_____ /_____

How did you respond? _____

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain: _____

_____

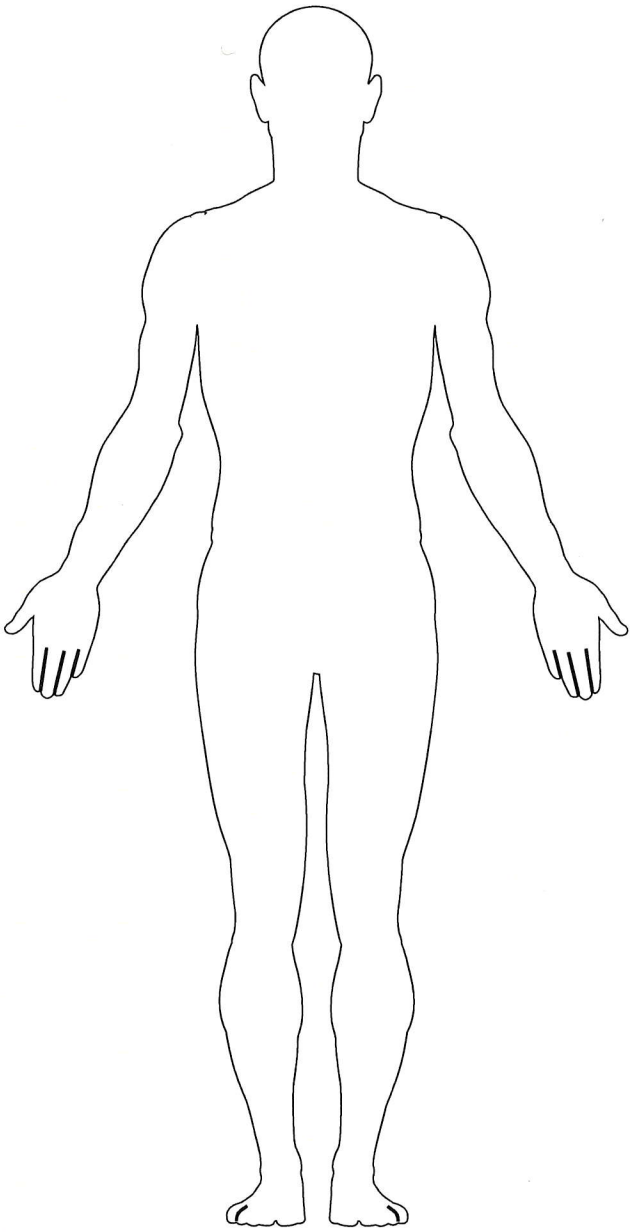
_____

_____

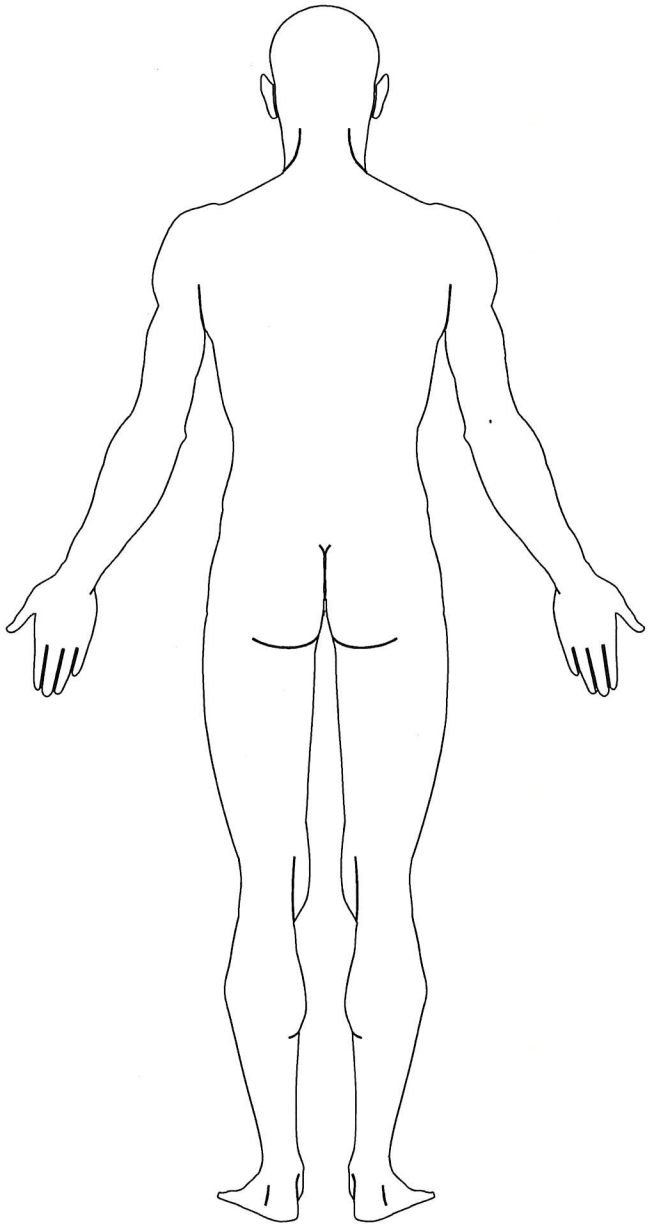
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often? _____ day(s) per week; Other: _____

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other: _____

Do you smoke? ❑ Yes ❑ No How much? / How often? _____

Do you drink alcohol? ❑ Yes ❑ No How much? / How often? _____

Do you drink coffee? ❑ Yes ❑ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain	____ Headaches	____ Sinusitis
____ Pain in shoulders/arms/hands	____ Dizziness	____ Allergies/Hay fever
____ Numbness/tingling in arms/hands	____ Visual disturbances	____ Recurrent colds/Flu
____ Hearing disturbances	____ Coldness in hands	____ Low Energy/Fatigue
____ Weakness in grip	____ Thyroid conditions	____ TMJ/Pain/Clicking

Please explain: _____

_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations	____ Recurrent Lung Infections/Bronchitis
____ Heart Murmurs	____ Asthma/Wheezing
____ Tachycardia	____ Shortness Of Breath
____ Heart Attacks/Angina	____ Pain On Deep Inspiration/Expiration

Please explain: _____

_____

_____

_____

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.*

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Nausea
____ Diabetes
____ Pain in Ribs/Chest
____ Ulcers/Gastritis
____ Hypoglycemia/Hyperglycemia
____ Indigestion/Heartburn
____ Reflux
____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

_____

_____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Weakness/injuries in hips/knees/ankles
____ Low back pain
____ Numbness/tingling in legs/feet
____ Recurrent bladder infections
____ Coldness in legs/feet
____ Frequent/difficulty urinating
____ Muscle cramps in legs/feet
____ Sexual dysfunction
____ Constipation/Diarrhea
____ Menstrual irregularities/cramping (females)

Please explain: _____

_____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ /_____ /_____

Patient's Signature _____ Date _____ /_____ /_____

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date _____ /_____ /_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____ /_____ /_____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Patient's Signature _____ Date _____/_____/_____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____/_____/_____

Relationship to Insured _____ Date of Birth _____/_____/_____

Employer _____

Primary Insurance Company _____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____-_____-_____

Secondary Insurance Company _____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____-_____-_____

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.
Room5Q9F HHH Building
Washington. DC 20201

This notice is effective as of April 1,2003
I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide Ploucha Chiropractic, P.C. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

Ploucha Chiropractic, P.C.

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.

Ploucha Chiropractic, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patents with notice to our legal duties and privacy practices with respect to your protected health information. '

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. (Example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Ploucha Chiropractic, P.C."

'It is our policy to provide a substitute health care provider, authorized by Ploucha Chiropractic, P.C. 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, other emergency situation.'

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations, (example)

> "As a courtesy to our patents, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Ploucha Chiropractic, P.C. for health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized tiling to your insurance carrier for the purpose of reimbursement lo you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

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 o» disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA 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 or any administrative of 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 (or 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 In* 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.

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below {example)

"As a *courtesy to* our *patients, it is our policy to call your home on the evening prior to* your scheduled *appointment to remind you of your appointment time. If you are not at home,* we leave a *reminder message on your answering machine or with the* person *answering the phone. No* personal *health information will be disclosed during the recoding or message other than the date and time of your scheduled appointment along* with *a request to call our* office *it you need to cancel or* reschedule *your appointment"*

It is our practice to *participate in* chartable events to raise awareness, food *donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home* to invite *you to participate in the* chartable *activity. We will provide you in writing information about the type of activity, the dates and times, and request your participation in such an event. Il is not our policy to disclose any personal* heath *information about your condition for the purpose of Ploucha Chiropractic Center sponsored fund-raising events."*

Change of Ownership.

In the event that Ploucha Chiropractic Center is 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 Ploucha Chiropractic, P.C. is 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 Ploucha Chiropractic, P.C. amend your protected health information. Please be advised. However, that Ploucha Chiropractic, P.C. is 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 made by Ploucha Chiropractic, P.C.

> 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

Ploucha Chiropractic, P.C. 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, Ploucha Chiropractic, P.C. is required by law to comply with this Notice.

Ploucha Chiropractic, P.C. is 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 Dr. Ron Ploucha by calling this office at •412.381-4422. If Dr. Ron Ploucha Is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Ploucha Chiropractic, P.C. has handled your health information should be directed to Dr. Ron Ploucha by calling this office at 412.381.4422. If Dr. Ron Ploucha is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Notice of Non-Discrimination

Ploucha Chiropractic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Ploucha Chiropractic, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo..

Ploucha Chiropractic, P.C. 遵守適用的聯邦民權法律規定. 不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。