Deerfield Health & Wellness Center

100 S. Military Trail #18 Deerfield Beach, FL 33442

Patient Health History

Date_____ Name_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Best phone number to reach you: _____

Would you like your appointments confirmed via Text Message? Yes or No **Carrier?** _____

E-mail Address_____ ❑Male ❑Female ❑Married ❑Single

Employer_____ Occupation_____

Emergency Contact_____ Relation_____ Phone _____

Who may we thank for referring you to us? _____

Do you have Insurance? Yes or No **Provider?** _____

What is your Primary Complaint? _____

When did it start?_____ What caused it? _____

Rate the pain - (0 is Pain Free - 10 is Unbearable Pain) 1 2 3 4 5 6 7 8 9 10

Are you currently under the care of a Physician? Yes or No

Have you ever had Chiropractic Treatment? Yes or No

Have you been told you need back surgery? Yes or No

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney Disease	Liver Disease	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia Prostate	Prosthesis Implants	Rheumatoid	Stroke	Thyroid	Tonsillitis	
Fibromyalgia	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure						

Other_____

Have you been in an Auto Accident? When? _____

Previous Surgeries, Accidents, Injuries? _____

List ALL Medications you are currently taking (including supplements) _____

What kind of exercise do you do? _____

Do you smoke? Y or N How many per day?_____ How many Drinks per week? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature _____ **Date** _____

Notice of Privacy Practices for Personal Health Information

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.

This Notice of Privacy Practices describes Deerfield Health and Wellness Center's practices for safeguarding individually identifiable personal health information (PHI). The terms of this Notice apply to patients of Deerfield Health and Wellness Center. This Notice is effective April 14, 2003.

We are required by law to maintain the privacy of our patients' PHI and to provide notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by us. Copies of revised Notices will b e mailed to patients of Deerfield Health and Wellness Center. You have the right to request a paper copy of the Notice.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to the address above.

Disclosures for Treatment. We may disclose your PHI as necessary for your treatment. For instance, another doctor or healthcare facility involved in your care may request your PHI in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your PHI as necessary for payment purposes. For instance, we may use your PHI with an insurer in order to process claims for your treatment.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Business Associate. Certain aspects and components of our services are provided by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your PHI to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your PHI.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your PHI relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your PHI without your approval. We may also disclose your PHI to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your PHI, without your authorization, in the foloowing circumstances: •For any purpose required by law; •For public health activities (for example, reporting of disease, injury, birth, death or suspension of child abuse or neglect); •To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence; •For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions); •For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request); •For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people); •To coroners and funeral directors; •For procurement, banking or transplantation of organ, eye or tissue donations; •For certain research purposes; To avert a serious threat to health or safety under certain circumstances; • For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody, and; •For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulations.

Your RightsRestrictions on Use and Disclosure of PHI. You have the right to request restrictions on how we use or disclose your PHI for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to the above address. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your PHI. You have the right to request communications regarding your PHI from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to the above address.

Access to Your PHI. You have the right to inspect and/or obtain a copy of your PHI we maintain in your designated record set, with a couple of exceptions. To request access to your information, you must send a written request..

Amendment of Your PHI. You have the right to request an amendment to your PHI to correct inaccuracies. To request an amendment, you must send a written request to the above address. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your PHI. To request an accounting, you must send a written request.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us or to the Secretary of the US Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact us at (954) 570-4080.

Name_____ Phone_____

Date_____

Deerfield Health & Wellness Center

Informed Consent for Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscles spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Name (print)_____

Patient Signature_____

Witness of Signature_____