SEWICKLEY CHIROPRACTIC CENTER, P.C.

Legal Name: _____ Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Home: (_____) _____-_____ **Work:** (_____) _____-_____ **Cell:** (_____) _____-_____

We use text messaging for appointment reminders. Who is your cell phone company: _____

Email Address: _____ **Social Security Number:** _____-_____-_____

Preferred Name: _____ Male _____ Female _____ **Date of Birth:** ____/____/____

If you are under 18 years of age, who are your legal parents or guardian?

Father/Mother/Guardian: _____ Phone: (_____) _____-_____

Who do you normally live with (check all that apply):

❑Father ❑Mother ❑Guardian/Foster Parent ❑Grandparent(s) ❑Brother(s)/Sisters(s) ❑None of these

Marital Status: ❑ Married ❑Single ❑Divorced ❑Widowed

Spouse's Name: _____ Number of children: ____ Names of children: _____

Occupation: _____ Employer: _____

Employers Address:_____ Phone: (_____) _____-_____

Student at _____ ❑FULL-TIME ❑ PART-TIME

Who should we contact in the event of an emergency? _____

Phone: (_____) _____-_____ Address of contact person: _____

Have you seen a Chiropractor before? ❑Yes ❑No If yes, when? _____

What is the reason for your appointment today: _____

_____

_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

❑ Headaches	❑ Pins and Needles in Legs	❑ Fainting	❑ Neck Pain
❑ Pins and Needles in arms	❑ Loss of Smell	❑ Back Pain	❑ Loss of Balance
❑ Dizziness	❑ Buzzing in ears	❑ Ringing in Ears	❑ Nervousness
❑ Numbness in Fingers	❑ Numbness in Toes	❑ Loss of Taste	❑ Stomach Upset
❑ Fatigue	❑ Depression	❑ Irritability	❑ Tension
❑ Sleeping Problems	❑ Neck Stiff	❑ Cold Hands	❑ Cold Feet
❑ Diarrhea	❑ Constipation	❑ Fever	❑ Hot Flashes
❑ Cold Sweats	❑ Lights Bother Eyes	❑ Problem Urinating	❑ Heartburn
❑ Mood Swings	❑ Menstrual Pain	❑ Menstrual Irregularity	❑ Ulcers

List all medications that you are taking: _____

_____

Date problem began: ____/____/____ Is it getting worse? ❑Yes ❑No Is it constant? ❑Yes ❑No Come and go? ❑Yes ❑No

Have you had a similar condition in the past? ❑Yes ❑No If so, when? _____

What have you done for this problem? _____

_____

Have you had spinal X-rays, MRI, CT Scans? ❑Yes ❑No When: ____/____/____ Where: _____

Have you been diagnosed with cancer? ❑Yes ❑No Year: _____ Type: _____

Family history: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Cardiovasular Problems/Stroke

Is your condition or injury due to an accident or work-related cause? ❑ YES ❑ NO

Please check ALL that apply:

Did the condition or injury result from an automobile accident? ❑ YES ❑ NO

Did it result from a work-related accident or cause? ❑ YES ❑ NO Briefly Describe: _____

_____

****if you have answered YES to any of the above questions, please see the Front Desk for additional paperwork.****

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ❑ YES ❑ NO ❑ UNCERTAIN

SEWICKLEY CHIROPRACTIC CENTER, P.C.

Do you have health insurance? ❑ YES ❑ NO

Insurance Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth: ____/____/____

Is the insurance through his/her employer? ❑ YES ❑ NO If yes, who is the Employer? _____

Primary Care Physician: _____

Phone: (_____) _____-_____ Address: _____

It is our office policy that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment.

Print Patient Name _____ Date: ____/____/____

Patient Signature: _____ Date: ____/____/____

Guardian Signature: _____ Date: ____/____/____

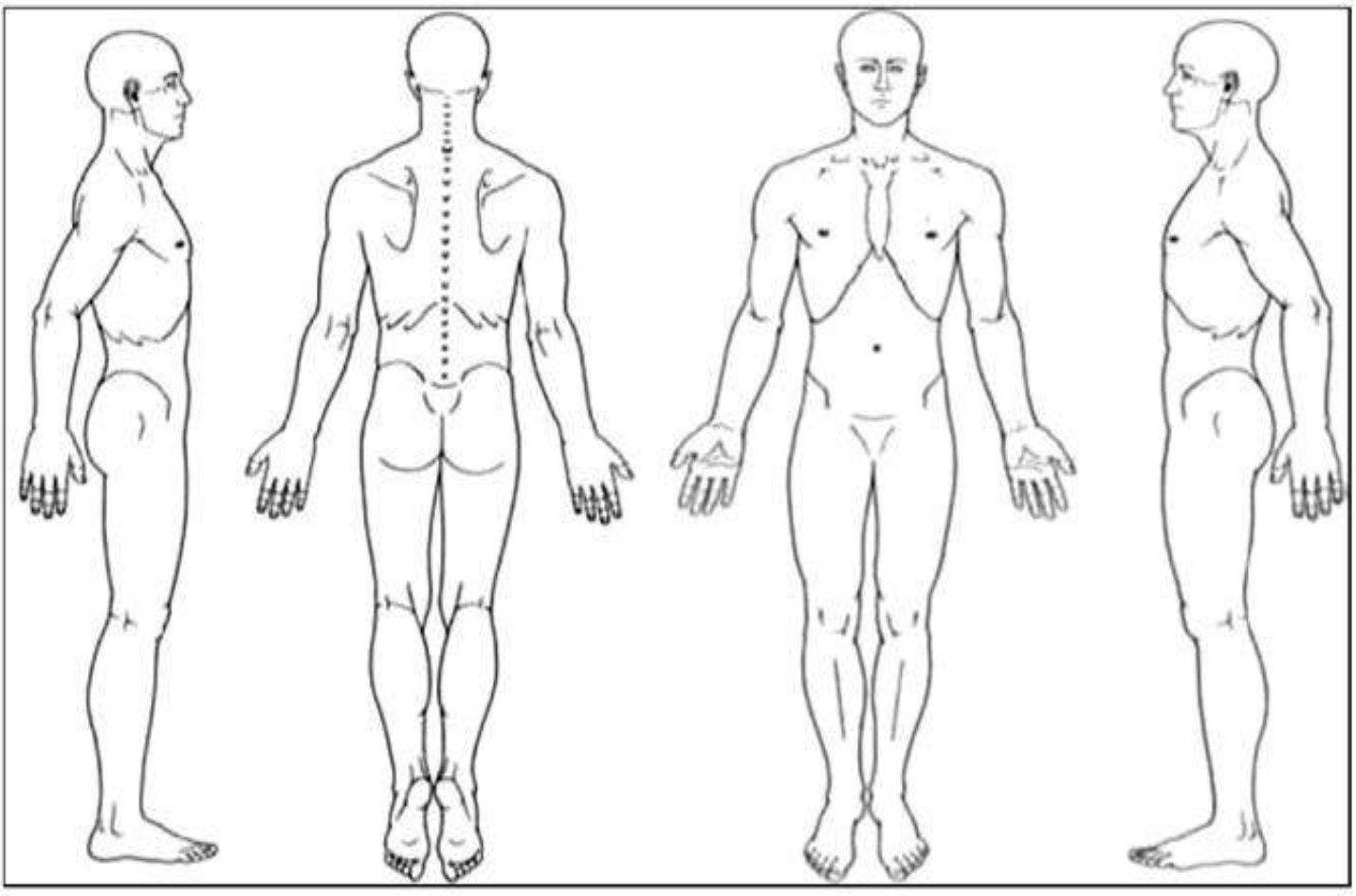
SEWICKLEY CHIROPRACTIC CENTER, P.C.

SYMPTOM DIAGRAM

Name: _____

Please be sure to fill this form out extremely accurate. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain and include all affected areas.

A = Ache B = Burning N – Numbness P = Pins and Needles S = Stabbing O = Other



Patient Signature: _____ Date: _____/_____/_____

SEWICKLEY CHIROPRACTIC CENTER CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been 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 or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from 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 the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

Signature:_____ **Date:**_____

Notice of Privacy Practices (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your

health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage,

and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

Privacy Officer, 409 Broad Street Suite 101 A, Sewickley, PA 15143

By Signing, I acknowledge that I have received a copy of the HIPAA privacy practices of Sewickley Chiropractic Center, P.C. and agree to the terms.

Signature:_____ **Date:**_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Benefits/Financial Responsibility

The undersigned hereby authorizes Sewickley Chiropractic Center P.C. (hereinafter "the Provider") to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment of any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

Designation of Authorized Representative

The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") as provided in 29 CFR 2560-503-1(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents, claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

Authorization for Release of Information

The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course

of examination or treatment. The undersigned hereby authorizes_____(employer) to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but is not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

Revocation and Acknowledgement

A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefit claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to the Provider; however, the undersigned understands that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature:_____ Date:_____

Release of Medical Records

I hereby authorize Sewickley Chiropractic Center, P.C. to release any and all medical records when necessary to requesting professional parties. This may include but is not limited to other physicians, attorneys, and insurance companies. I understand that records will only be released in accordance with HIPAA as described above and will not be released to parties not having direct interests in my case. This authorization will be ongoing unless I submit in writing that it should be terminated.

Signature:_____ Date:_____