## Welcome to Northeast Chiropractic Center

Patient Information		
·	_	chiropractic needs. Please complete this form in ink. ask for assistance. We are happy to help.
(please print clearly)		
Name:		SS/HIC/Patient ID #:
First Addresses	Middle Initial Last	States 7in Codes
		State: Zip Code:
		mail: Work Phone: ()
Do you prefer to receive calls at:		
	•	rated Divorced Partnered for years
		Occupation:
_ :		State:Zip Code:
		Work Phone: ()
		Dhonor ( )
Person to contact in case of emer	gency:	Phone: ()
Responsible Party		
		Phone: ()
		State: Zip Code:
		Work Phone: ()
Insurance Information	<i>1</i>	
		onship to patient:
		Date employed:
	•	Work Phone: ()
		State: Zip Code:
	•	Group #: Employer #:
		State: Zip Code:
		sed? Max. annual benefit?
Do you have additional insuran	ace?  \( \subseteq \text{ Yes} \) No	If Yes, please complete the following:
Name of insured:	Relatio	onship to patient:
		Date employed:
		Work Phone: ()
		State: Zip Code:
		Group #: Employer #:
		State: Zip Code:
	•	sed? May annual benefit?

Symptoms				
Reason for visit:		When did you firs	st notice the symptoms? _	
Is the condition getting pro				
Which activities are difficu	alt to perform?	ng 🖵 Standing 🖵 Walk	ing 🖵 Bending 🖵 Lyi	ng down 🖵 Other
	□ Dull □ Tingling □ (	Throbbing ☐ Numbne Cramps ☐ Stiffness	ss Aching Swelling	
Rate the severity of your p	ain. (1 = mild pain or disc	omfort, to 10 = severe pa	in) 1 2 3 4 5 6	7 8 9 10
Is the pain constant or does	s it come and go?			
What treatment have you r	eceived for your condition	?		
☐ Medication ☐	Surgery  Physical T	herapy 📮 Other		
Name and address of other	doctor(s) who have treate	d you for your condition:		
Health History Ch	eck only those conditions	which are applicable: .		
□ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
Allergy Shots	☐ Chicken Pox	Herniated Disc	Parkinson's Disease	☐ Tonsillitis
Anemia	Depression	☐ Herpes	Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	□ Polio	☐ Typhoid Fever
☐ Arthritis ☐ Asthma	☐ Epilepsy☐ Fractures	☐ Liver Disease☐ Measles	<ul><li>☐ Prostrate Problems</li><li>☐ Prosthesis</li></ul>	<ul><li>Ulcers</li><li>Vaginal Infections</li></ul>
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	Other
Bulimia	☐ Gout	Multiple Sclerosis	☐ Scarlet Fever	
☐ Cancer	Heart Disease	☐ Mumps	☐ Stroke	
Dates of last exams:				
(Woman) Are you pregnan			Taking Birth Control	Pills? □Yes □No
List any types of surgeries		_	•	
Please list all medications	you are currently taking: _			
Allergies:				
Daily Habits				
What type of exercise do y	1		_	
What do your daily work h	abits include?			
What vitamins do you curr	ently take?	Nutritional supp	plements (if any)?	
Do you smoke?	□ No How much per	day?	• • • • • • • • • • • • • • • • • • • •	
How much liquor do you c				
Certification and	Assignment			
To the best of my knowled my doctor if I, or my mino			I understand that it is my	responsibility to inform
I certify that I, and/or my cand assign directly to Dr. E understand that I am financon all insurance submission	cially responsible for all ch	ce coverage with	payable to me for service by insurance. I authorize	es rendered. I fully the use of my signature
Dr. Eric Springer may use Company(ies) and their age benefits payable for related date signed below.	ents for the purpose of obta	aining payment for service	es and determining insura	nce benefits or the
Signatur	e of Patient, Parent, Guardian or Persona	I Representative		Date

# 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 READ CAREFULLY

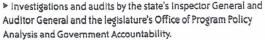


#### Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected

health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings.



- ▶ Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- ▶ District medical examiner investigations.
- ▶ Research approved by the department.
- > Court orders, warrants, or subpoenas.
- ► Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.



#### Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual.

Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the dinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health dinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- ► Reporting abuse of children, adults, or disabled persons.
- ► Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.



#### **Individual Rights**

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment,

payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

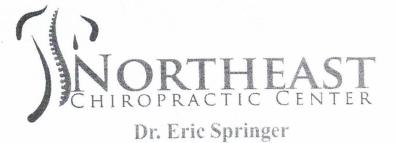
You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- is not protected health information,
- > Is by law not available for your inspection, or

▶ Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.



Chiropractic Physician

### NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Signature	Date
CC	DNSENT TO TREATMENT
procedures, including various modes of spinal decompression, therapeutic modes of the procedure of the proce	rformance of chiropractic adjustments and other chiropractic of physical therapy, neuromuscular re-education, spinal traction, dalities, including but not limited to, Ultrasound and EMS and attient named below, for whom I am legally responsible) by the ad/or other licensed doctors of chiropractic who now or in the future or any other office or clinic.
I have had an opportunity to discuss we or clinic personnel the nature and purpose that results are not guaranteed.	with the doctor of chiropractic named below and/or with other office pose of chiropractic adjustments and other procedures. I understand
some risks to treatment, including but sprains. I do not expect the doctor to wish to rely upon the doctor to exerci	in the practice of medicine, in the practice of chiropractic there are not limited to fractures, disc injuries, strokes, dislocations and be able to anticipate and explain all risks and complications, and is ejudgment during the course of the procedure which the doctors then known to him or her, is in my best interest.
about its content, and by signing belo	the above consent. I have also had an opportunity to ask questions ow I agree to the above-named procedures. I intend this consent for the formy present condition and for any future condition(s) for which
Doctor Signature Eury	Injer Sato
Patient Signature	Date