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Ballenger Creek Chiropractic

604 Solarex Court
Suite 101
Frederick, MD 21703

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name :**_____ **Last Name:**_____

**Email address:**_____@_____

**Preferred method of communication for patient reminders** (Circle one) Email/Phone/Mail

**DOB:**___/___/_____ **Gender (Circle one)** Male/Female **Preferred Language:** _____

**Smoking Status (Circle one)** Every Day Smoker/ Occasional Smoker/Former Smoker/ Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native/Asian/Black or African American/ White(Caucasion) Native Hawaiian or Pacific Islander/ Other / Decline to answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

**Medication Name** **Dosage & Frequency** (i.e. 5mg once a day,etc.)

**Do you have any medication allergies?**

**Medication Name** **Reaction** **Onset Date** **Additional Comments**

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date: _____

***For Office Use Only***

**Height:**_____ **Weight:**_____ **Blood Pressure:** _____/_____

**Dr. Brandon Steinbar**
**Dr. Cassie Dougherty**

Ballenger Creek Chiropractic

**604 Solarex Ct., Suite 101**
**Frederick, MD 21703**
**301-620-1008**

Name:_____ Date of Birth:_____

Please read the included documents, and initial or make a check mark by each, signifying that you have read and understand each of the included documents and information.

_____ I have read and fully understand and agree to the terms and information included in the document: **HIPAA NOTICE OF PRIVACY PRACTICES.**

_____ I have read and fully understand and agree to the terms and information included in the document: **INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE.**

_____ I have read and fully understand and agree to the terms and information included in the document:

**MEDIA RELEASE.**

_____ I authorize Ballenger Creek Chiropractic to release and receive: all records and reports (for past, present, and future conditions), x-rays and reports, foot scan results, examination findings and interpretations, diagnoses, treatments, and any other information that may improve the communication between my healthcare providers and assist in the continuity of my care. This information may be sent to and/or received by any of my healthcare providers (including past, present, and future providers) including but not limited to: primary care physicians, naturopaths, dentists, psychologists, surgeons, pain specialists etc.

_____ If the above named patient is a minor or is incapable of making sound medical decisions, I agree that I am a parent or legal guardian of him/her, and I have read, understand, and agree to all of the terms and information in the subsequent documents.

By signing this sheet, I certify that I have read, fully understand, and agree to the terms of the information listed and included documents.

**Signature:**_____ **Date:**_____

## HIPAA 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.

### Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

### How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

**Treatment**. We may use and disclose Health Information (HI) for your treatment and to provide you with treatment-related healthcare services. For example, we may disclose Health Information (HI) to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment**. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the chiropractic care you receive is of the highest quality. We may also share information with our entities that have a relationship with you (for example your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We may also use related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** We may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

### Special Situations

**As required by law.** We will disclose Health Information when required to do so by international, federal, state, or local law.

**To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.**

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any other information other than that as specific in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may use or disclose Health Information as required by military command authorities. We may also release Health Information to the appropriate foreign military authority of you are a member of a foreign military.

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or are required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We may also disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we may believe is a result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so that they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

**Your Rights**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

**Changes to This Notice**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

**Complaints**

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact out Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By initialing, making a check mark, and/or signing the front page of this document, I acknowledge, understand, and agree to the terms of this document.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form.

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various methods of physical therapy on me (or the patient named on the summary page, for whom I'm legally responsible) by the doctor named below and/or other licensed doctors of chiropractic, or student interns working under the supervision of a licensed doctor of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with the office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing, initialing, and/or making check marks on the summary sheet, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Office: Ballenger Creek Chiropractic

604 Solarex Ct #101

Frederick, MD 21703

Drs Brandon Steinbar, DC and Cassandra "Cassie" Dougherty, DC

## MEDIA RELEASE

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby give consent, and forever grant to Dr. Cassie Dougherty, Dr. Brandon Steinbar and Ballenger Creek Chiropractic, its representatives, licensees, marketers, and any other related parties or publishers of its promotional materials and their successors and assigns, the right to use, publish, and copyright my (or people who I hold legal guardianship of) picture, portrait, or likeness, in video and film format, in whole or in part, including alterations, modifications, derivations, and composite thereof, in CDs, films, advertising and similar such promotions and renditions throughout the world. This right shall include the right to combine my likeness with others and to alter my likeness by digital or other means.

I hereby release Ballenger Creek Chiropractic and other such parties from any obligation to make any payment hereunder or from any other liability incurred in connection with the use of any of the materials described above.

I am aware that I have the right to request exclusion from media materials. Such requests must be made in writing, and do not apply to previously released or published articles.

By initialing, signing, and/or by making check marks on the first page (summary page), I acknowledge full and complete satisfaction with the terms of this release.