Greene Chiropractic Clinic

1507-B Stillwater Ave, Cheyenne, WY 82009
Office: 307-637-7463 Fax: 307-778-9814
www.cheyennechiro.com

CONFIDENTIAL PATIENT INTRODUCTION

Date: _____

Patient's Full Name: _____ **Nickname:** _____
(Title) (First) (Middle Initial) (Last)

Primary Address: _____
(Street) (City) (State) (Zip Code)

Mailing Address *(if different)*: _____

Date of Birth: _____ **Age:** _____ **Sex:** __Male __Female **S.S.N.** _____ - _____ - _____

Marital Status: ☐ S ☐ M ☐ W ☐ D **Driver's License State and Number:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Preferred method of contact for appointment reminders:

☐ Home phone ☐ Work phone ☐ Cell phone ☐ Text message to cell (Wireless carrier: _____)

☐ E-mail -- E-Mail Address: _____

Would you like to receive monthly newsletters and special announcements by e-mail? ☐ Yes ☐ No

Employer (or School): _____ **Job Title:** _____

Name of Spouse: _____ **Is Spouse a Patient here?** _____

Emergency Contact: _____ **Relation to you:** _____

Contact's Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Who referred you to our office (or how did you find out about us)? _____

INSURANCE INFORMATION: **Health Savings or Flex Spending Account?** ☐ Yes ☐ No

Primary Insurance Company: _____ **Policy #** _____

Insured's Name: _____ **Employer:** _____

Insured's Date of Birth: _____ **Insured's S.S.N.** _____ - _____ - _____

Secondary Insurance Company: _____ **Policy #** _____

Insured's Name: _____ **Employer:** _____

Insured's Date of Birth: _____ **Insured's S.S.N.** _____ - _____ - _____

(We will need a copy of your insurance cards and driver's license for our records)

AUTHORIZATION TO BILL INSURANCE & RELEASE INFORMATION:

I hereby authorize my insurance company(ies) to pay directly to Greene Chiropractic Clinic all benefits due under said policy(ies) by reason of services rendered therein. Greene Chiropractic is authorized to release to any insurance companies having coverage on me any of my medical records pertaining to services rendered at this office. A copy of this authorization shall be considered as effective and valid as the original.

_____ _____

(Patient Signature) **(Date)**

CONFIDENTIAL MEDICAL HISTORY FOR: *(Please be complete)*

Greene Chiropractic Clinic
1507 B Stillwater Ave.
Cheyenne, WY 82009

Name: _____ **Height:** _____ **Weight:** _____

List any allergies or health conditions you have: _____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.):

_____

Have you been under a physician's care in the past year? ☐ **no** ☐ **yes (reason)** _____

When was your last physical examination? _____

Have you ever been under chiropractic care? ☐ **no** ☐ **yes (describe)** _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates & reason): _____

List any on the job injuries (include dates): _____

If female, is there a possibility that you are pregnant? ☐ **no** ☐ **yes**

Do you smoke/use tobacco? ☐ **no** ☐ **yes** **Exercise habits?** ☐ **never** ☐ **occasionally** ☐ **frequently**

Check any of the following symptoms you have noticed: (☐ = Now, △ = Past)

☐ △ Headaches	☐△ Leg/foot numbness/tingling	☐ △ Irritability or depression
☐ △ Dizziness or light-headed	☐ △ Leg/foot fatigue/weakness	☐ △ Fatigue or loss of energy
☐ △ Muscles jerking/twitches	☐ △ Leg pain with walking	☐ △ Fainting or convulsions
☐ △ Jaw pain, clicking, or locking	☐ △ Radiating pain	☐ △ Trouble w/ balance or coordination
☐ △ Pain or difficulty swallowing	☐ △ Abdominal pain	☐ △ Difficulty breathing
☐ △ Neck pain or stiffness	☐ △ Nausea or vomiting	☐ △ Sleep disturbances/problems
☐ △ Shoulder pain	☐ △ Diarrhea or constipation	☐ △ Rashes (face, body, limbs)
☐ △ Mid back pain	☐ △ Blood in urine or stool	☐ △ Joint pain or swelling
☐ △Chest pain or cough	☐ △ Difficulty or pain w/ urination	☐ △ Osteoporosis/loss of bone density
☐ △ Pain/trouble breathing	☐ △ Loss of bowel or bladder control	☐ △ Pain w/ exertion (activity, stairs)
☐ △ Blood pressure problems	☐ △ Abnormal menstrual periods	☐ △ A sore that won't heal
☐ △ Arm/hand numbness/tingling	☐ △ Sensitive to light or sound	☐ △ Unexplained weight loss
☐ △ Arm/hand fatigue/weakness	☐ △ Visual or hearing disturbances	☐ △ Tumors
☐ △ Low back pain	☐ △ Memory loss/confusion	☐ △ Bleeding disorders

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

Any recent accidents or injuries (describe)? _____

How did your symptoms first begin? _____

Pain is: ☐ **Constant** ☐ **Intermittent** ☐ **Getting worse** ☐ **About the same** ☐ **Somewhat less**

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

Is your condition worse at certain times of the day or night? _____

Have you had symptoms like this before? ☐ **no** ☐ **yes (describe)** _____

Does your condition interfere with: (yes/no) work _____ **sleep** _____ **normal daily routine** _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

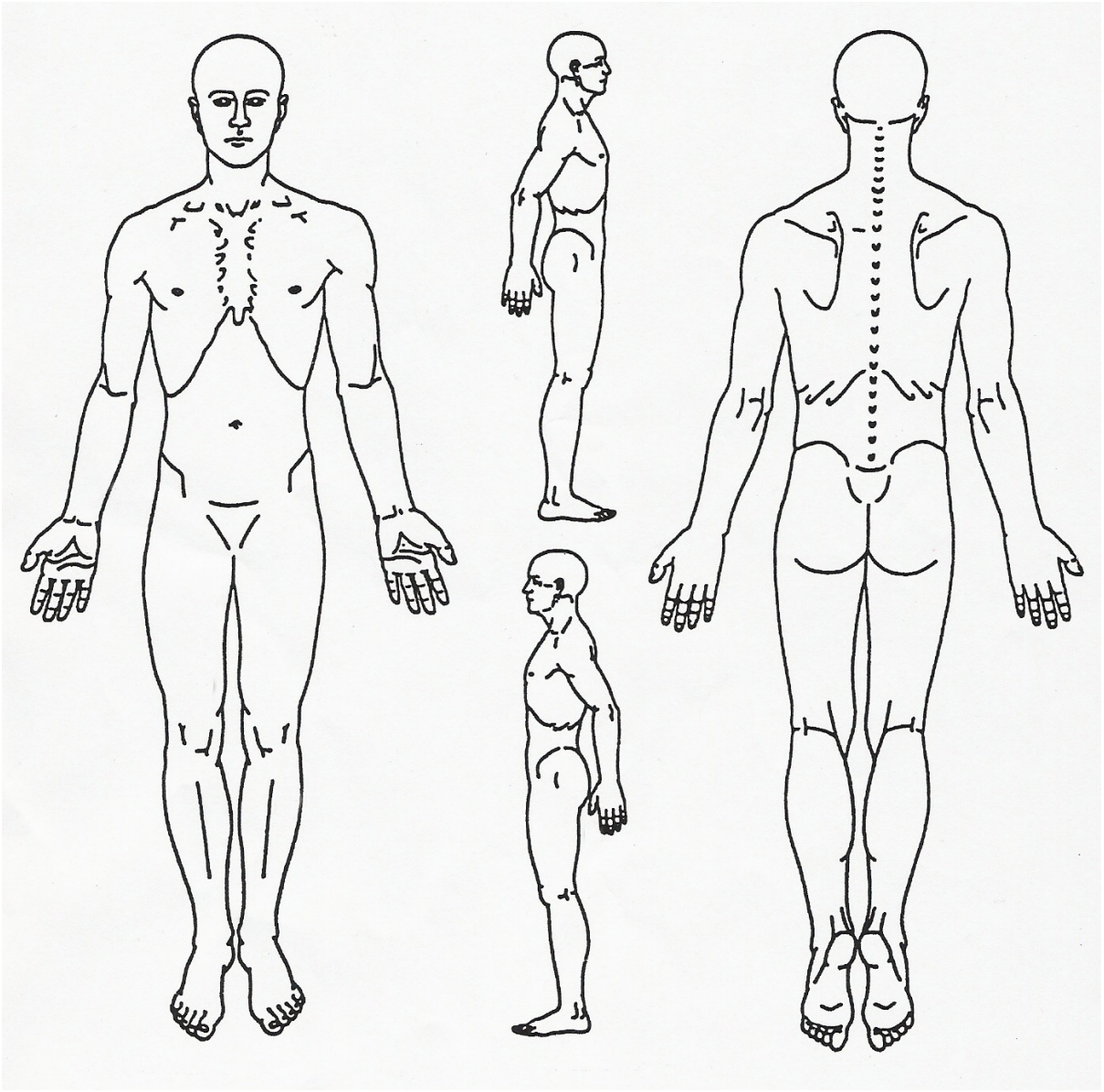
_____

Who is your family medical doctor? _____

PAIN DRAWING *(page 3)* **GREENE CHIROPRACTIC CLINIC**

Mark areas where you feel pain using the symbols below. Mark the areas where pain radiates or spreads with an ↑, ↓, or ←, → arrow to indicate the direction of radiating pain as far as the pain travels. *(Include <u>all</u> affected areas)*

Aching >>>>>>>>>>>>	**Burning** XXXXXXXXXXXX	**Throbbing** ~~~~~~~~~
Numbness ==========	**Stabbing** /////////////////	**Pins & Needles** 000000000000



Rate your level of pain for each area. It is important to document **<u>all</u>** recent and current areas of discomfort to determine the most appropriate diagnosis and treatment plan for you at this time. Name additional or specific areas of pain (jaw, ribs, elbow, wrist, knee, ankle, etc.) in the boxes to the right below. Circle the appropriate number to indicate today's pain and use an X to indicate how high the pain can get at times.

Head/Neck	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>	**Shoulder**	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>
Upper Back	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>	**Arm/Hand**	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>
Lower Back	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>	**Leg/Knee/Foot**	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>
Hips	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>	**Other** _____	= <u>(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)</u>

NAME _____ **DATE:** _____

Greene Chiropractic Clinic

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INFORMED CONSENT & FINANCIAL AGREEMENT FOR CHIROPRACTIC CARE

I, _____, do hereby agree to all of the following stipulations:
(Please print name here and sign below)

- When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
- Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are done by hand. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.
- I have read and fully understand the above statements and therefore accept chiropractic care on this basis. I hereby grant permission for myself (or my child) to receive chiropractic care.
- I understand and agree that all services rendered to me are charged directly to me, and that I am responsible for payment to Greene Chiropractic Clinic for all such services at the time that they are rendered. Payment is required at each visit, unless payment arrangements are made.
- I fully understand and agree that my insurance policy(ies) are an arrangement between the insurance carrier(s) and myself. I will be responsible for expenses not paid by insurance, including insurance deductibles, co-insurance, and co-payment amounts. I understand and agree that health or automobile insurance may not pay in full all of the charges incurred for my treatment. I understand and agree to pay the customary charges of Greene Chiropractic Clinic and agree that if my health or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance.
- If I default in this agreement the entire balance becomes due, and I may be liable for court costs and attorney fees necessary to enforce collections of this debt. I understand that if I suspend or terminate my treatment, any fee for professional services rendered me will be immediately due and payable. An unpaid balance will be charged at the customary rate of one and a half percent (1.5 %) per month. I will be responsible for any legal expenses involved in the collection of such a past due account.
- **I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Privacy Practices (following this page).**

_____ _____
Signature of Patient *(Date)*

_____ _____
Signature of Guardian (for Minor) *(Date)*

HIPAA Notice of Privacy Practices of
GREENE CHIROPRACTIC CLINIC

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Phone: 307-637-7463 Fax: 307-778-9814

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 describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.
Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.
Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Appointment Reminders. We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment at Greene Chiropractic Clinic. We may need to leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.
Release to Family/Friends. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
Newsletters and Other Communications. We may use your personal information in order to communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, birthday greetings, or other community based initiatives or activities in which our practice is participating.

YOUR HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the equest. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for Greene Chiropractic Clinic;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

Personal Representative: If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Greene Chiropractic Clinic - 2014