



Community Chiropractic Center

Let Us Help Your Body To Help Itself

Name _____ Preferred Name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email _____

SS# _____ Birthdate _____

Occupation _____ Employer _____

Marital Status single married separated divorced widowed

Emergency Contact: Name _____ Phone # _____

What Brings You Here?

Have you ever had chiropractic care before? Yes No

If yes, please provide the doctor's name _____ Phone _____

How did you find out about our office? _____

Is this appointment related to: Auto Accident/Personal Injury Workers' Compensation Other

When did the incident occur? _____

Attorney _____ Phone _____

Are you receiving care from other health professionals? Yes No

If yes, please provide their name and specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathics/other you are taking _____

Health Profile

Our goals here at Community Chiropractic Center are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the questions on this form will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to *General History*.

Briefly describe your symptoms: _____

When did this episode start? _____ Did problem begin with an injury? Yes No

Average Pain intensity (please circle):

Last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Past Week: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

Constantly (76-100% of the time) Frequently (51-75% of the time)

Occasionally (26-50% of the time) Intermittently (0-25% of the time)

If you experience pain, is it . . . Sharp Dull Throbbing Burning Aching

Does the pain travel/radiate? Yes No

If yes, please describe _____

Since the problem started, is it . . . about the same getting better getting worse

What makes it worse? _____

What makes it better? _____

Does this condition interfere with your: Work Sleep Activities?

Have you seen other health professionals for this condition? Yes No

If yes, please provide name and specialty _____

Phone _____ Diagnosis _____

Date _____ Treatment _____

General History

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

<input type="checkbox"/> Headaches	<input type="checkbox"/> Tingling in arms	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Back pain	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of smell/taste	<input type="checkbox"/> Irritability	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Tingling in legs	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Upset stomach
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Menstrual pain/irregularity	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Tension	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Migraines	<input type="checkbox"/> Abnormal blood pressure	<input type="checkbox"/> Allergies	<input type="checkbox"/> Chest pain

Have you had any surgery?

1. Type _____ Date _____ Doctor _____

2. Type _____ Date _____ Doctor _____

Please list any accidents and/or injuries:

1. Type _____ Date _____ Hospitalized? Yes No

2. Type _____ Date _____ Hospitalized? Yes No

Have you ever had x-rays taken? When _____ Area of body: _____

On a scale of 0-10, rate your stress levels (0=none 10 = extreme): Personal _____ Occupational _____

On a scale of 0-10, rate the following (0=very poor 10=excellent): Eating habits _____ Exercise habits _____ Sleep _____

The above is accurate to the best of my knowledge.

Patient (Print Name)

Patient's Signature or Guardian of Said Minor

Date

Office Policies

Appointments

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. The frequency of visits outlined in your Treatment Plan is of paramount importance to your results so we ask that each patient assume the responsibility of strict adherence to the Treatment Plan as it is designed for optimum results.

If, for any reason, you are unable to keep an appointment, we require that you telephone immediately to reschedule that visit. This office reserves the right to charge for missed appointments and those appointments canceled without 24 hours notice.

Insurance/Financial Policy

I understand and agree that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. Furthermore, I understand that Community Chiropractic LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Community Chiropractic LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting my account.

Insurance Information

Insurance Co. _____ Phone _____
Member ID/SSN _____ Group/Policy No. _____
Insured's Name _____ Relationship to Insured _____
Insured's DOB _____ Insured's Employer _____

Authorization of Care

I hereby authorize the staff to perform any services deemed necessary during diagnosis and treatment. It is understood and agreed the x-rays are for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient in this office. I also clearly understand that if I do not follow the Doctors' specific recommendations at this clinic that I will not receive the full benefit from care.

I, _____, do hereby give my consent to allow Community Chiropractic LLC and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities. I also hereby declare that to my knowledge that I am not pregnant _____ (initials).

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to a doctor-patient relationship that works for our mutual benefit!

Patient (Print Name)

Patient's Signature or Guardian of said Minor

Date

Community Chiropractic LLC
Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

I consent to the use or disclosure of my protected health information by Community Chiropractic LLC for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Community Chiropractic LLC. I understand that analysis, diagnosis or treatment of me by Community Chiropractic LLC may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Community Chiropractic LLC is not required to agree to the restrictions that I may request. However, if Community Chiropractic LLC agrees to a restriction that I request, the restriction is binding on Community Chiropractic LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Community Chiropractic LLC has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Community Chiropractic LLC prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Community Chiropractic LLC. The Notice of Privacy Practices for Community Chiropractic LLC is also posted at the front desk at 7175 N. Durango Drive, Suite 240, Las Vegas, NV 89149. This Notice of Privacy Practices also describes my rights and duties of Community Chiropractic LLC with respect to my protected health information.

Community Chiropractic LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Community Chiropractic LLC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

Community Chiropractic LLC
Notice of Privacy Practices (3/03)

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. 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.

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 your 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 your 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, Community Chiropractic LLC
7175 N. Durango Dr., #240
Las Vegas, NV 89149