Health 1st Chiropractic Clinic

REGISTRATION AND HISTORY

Name _____ E-Mail _____
Address _____City _____ State _____ Zip _____
Date of Birth _____/_____/_____ Age _____ Number of Children _____ Marital Status _____
Home Telephone (____) _____Work (____) _____Occupation _____
At this time do you have any type of health insurance? Yes ___☐___ No ___☐___
If you answered yes, please list: _____
Whom may we thank for referring you? _____
Interested in (Check All That Apply) ☐ Nutrition ☐ Diet/Exercise ☐Acupuncture ☐ Wellness

HEALTH INFORMATION

Have you had previous chiropractic care? YES☐ NO ☐
Main complaint _____
Other complaints _____
How long have you had this condition? _____ Have you had similar conditions in the past? _____
Does this condition affect your family or social life? _____
What aggravates this condition? _____
Have you been treated by another medical doctor for this same condition? _____
Are you currently taking any medications? Yes _____ No _____ If yes please list: _____
_____
What helps your symptoms? _____
Have you had any surgery, falls or accidents? Yes ☐ No ☐When? _____
Please describe _____
_____
Date of last physical examination _____

SYMPTOM CHECKLIST

Abdominal Pain ----------YES ☐ NO☐
Anemia ----------YES ☐ NO☐
Arm/Shoulder Pain ----------YES ☐ NO☐
Back Pain----------YES☐ NO☐
Bladder Problems ----------YES ☐ NO☐
Circulatory Problems ----------YES ☐ NO☐
Depression ----------YES ☐ NO☐
Diabetes ----------YES ☐ NO☐
Dizziness ----------YES ☐ NO☐
Fatigue ----------YES ☐ NO☐
Headaches ----------YES ☐ NO☐
Sinus Problems ----------YES☐ NO☐

High/Low Blood Pressure-------YES☐ NO☐
Hip or Leg Pain----------YES☐ NO☐
Insomnia----------YES☐ NO☐
Kidney Problems----------YES☐ NO☐
Lung/Bronchial Disorder------YES☐ NO☐
Memory Problems----------Yes☐ NO☐
Neck Pain----------YES☐ NO☐
Numbness ----------YES☐ NO☐
Palpitations ----------YES ☐ NO☐
Prostate Disorder ----------YES ☐ NO☐
Swollen Joints----------YES☐ NO☐

I understand and agree that health and accident insurance are an arrangement between an insurance carrier and me. Furthermore I understand that the chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from my insurance company and that any amount authorized will be paid directly to the chiropractor and credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if termination or suspension of treatment occurs, total payment for services rendered, which I am held accountable for will be due immediately.

PATIENTS SIGNATURE _____DATE_____

Health 1st Chiropractic (313) 227-0404

Authorization for Chiropractic Treatment

I _____, a patient in this office hereby authorize Dr. Bashar Salame or Dr. Naiel Salameh to administer such treatment as considered necessary on the basis of findings during the course of said treatment.

I hereby authorize that I have read and understand the above **Authorization for Chiropractic Treatment,** the reasons why the above named treatments are considered necessary, it's advantages and possible complications, if any, as well as possible alternative treatment, which were explained to me by the doctor. I also confirm that no guarantee or assurance has been made as to the result that may be obtained.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires for us to give you this disclosure, please understand that we have and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

*****Information that we use or disclose based on the authorization you are giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You're right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restriction is binding on us. You may revoke your authorization to us at any time; however, your revocation must be in writing, either in person or mailed to our office. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have a right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I have read your consent policy and agree to its terms. In addition, I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this notice.

_____ _____

PRINTED NAME PATIENT SIGNATURE

_____ _____

AUTHORIZED REPRESENTATIVE DATE