Active Life Chiropractic

Welcome to the Office of Dr. Gary Smith (360) 825-2225

Patient Health Record

Please fill out our confidential patient health record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being through gentle and very specific Chiropractic care.

About the Patient

Today's Date _____ Date of Injury _____
How did you hear about us? _____
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Email Address: _____
Age: _____ Birth date: _____/_____/_____ Gender: _____M_____F
Social Security #: _____ Number of Children: _____
Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Patient Employment

Business Name: _____
Employer's Name: _____
Type of Work: _____ Work Phone: (____) _____
Work Address: _____

Who do we Contact in the Event of an Emergency:

Name: _____ Relation to you: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____

For Women:

Y or N Are you pregnant?
Y or N Are you nursing?
Y or N Are you taking birth control?
Y or N Do you experience painful periods?
Y or N Do you have irregular cycles?
Y or N Do you have breast implants?

Concerns about Chiropractic Care

Y or N Adjustments may hurt?
Y or N Care may cost too much?
Y or N Care may last too long?
Y or N May be schedule problems?
Y or N Chiropractic care may not work?
Y or N Too much of a time commitment?

Reason for this Visit

This appointment is related to which of the following:

- ☐ Home injury
- ☐ Work injury
- ☐ Auto injury
- ☐ Sports injury
- ☐ Chronic discomfort
- ☐ Starting a corrective care plan

If job related, have you filed a report with your employer or Labor & Industries? Y or N

If auto related, have you filed a report with your insurance company? Y or N

Adjuster's Name _____ Adjuster's Phone # _____ Claim #_____

What condition do you wish Chiropractic care to help, please be as detailed as possible:

1.) _____ 3.) _____

2.) _____ 4.) _____

- Which condition:
  - Has gotten worse? 1 2 3 4
  - Has stayed constant? 1 2 3 4
  - Comes & goes? 1 2 3 4
- Which condition has occurred before? 1 2 3 4
- Indicate the condition # and what makes this condition feel
  - Better? 1 2 3 4 _____
  - Worse? 1 2 3 4 _____
- Circle all that applies - What type of pain is it?
  - 1234- Radiating 1234- Sharp 1234- Burning 1234- Throbbing
  - 1234- Dull 1234- Stabbing 1234- Aching 1234- Other _____
- Which condition's pain:
  - Stays in one area of the body? 1 2 3 4
  - Extends to other areas? 1 2 3 4
- Which condition's pain is worse in the:
  - Morning? 1 2 3 4
  - Night? 1 2 3 4
- Which condition pain wakes you up? 1 2 3 4

Have you been seen by anyone for this condition prior to this visit? Y or N _____

Type of treatment: _____ Results: _____

How committed are you in getting rid of this health concern?

1 is Low / 10 is high **1 2 3 4 5 6 7 8 9 10**

History

Please list any **surgeries** you have had, and how many years ago you had it:

_____

_____

Please list any major **injuries** you have had in your past:

_____

_____

_____

Do you smoke?	Y or N
Do you drink alcohol?	Y or N
Do you drink caffeine?	Y or N
Do you exercise regularly?	Y or N
Do you stretch regularly?	Y or N

Would you like a *FREE* scan that would determine if you need custom orthotics? Y or N

Please List **All** medications you are now taking, including nonprescription and prescription:

_____

_____

Please Circle each conditions or problems that you have now or have had in the past.

Jaw pain	Pins and needles in arms/hands	Allergies
Headaches	Pins and needles in legs/feet	HIV
Neck pain	Spinal injury	Hepatitis
Pain between shoulders	Numbness in legs/feet	Depression
Mid back pain	Numbness in arms/hands	STD's
Low back pain	Fusion of spinal bones	Smelling changes
Tail bone pain	Herniation of spinal disc	Ulcers/Colitis
Shoulder pain	Any Arthritis	Anemia
Elbow pain	Sinus problems	Spinal surgery
Arm pain	Congenital heart defect	Ringing in ears
Wrist pain	Heart surgery/Pacemaker	High or Low blood pressure
Hand pain	Heart attack/Stroke	Diabetes
Finger pain	Heart murmur	Difficulty breathing
Knee pain	Stress	Chrohn's disease
Hip pain	Fatigue	Cancer
Leg pain	Organ problems	Psychiatric problems
Ankle pain	Sleeping problems	Thyroid problems
Foot pain	Skin problems	Asthma
Tension	Dizziness	Stomach problems
Scoliosis	Constipation	Alcohol/Drug abuse
Plates, rods or screws	Visual changes	Liver problems
DJD	Ear problems	Sexual abuse

Please list any other condition not listed _____

* Can you think of any experience or condition you had or have that would affect your care in this office? If YES please explain _____

Goals for Your Care

People see Chiropractors for a variety of reasons. Please indicate your choice.

- Corrective Care - Correcting and relieving the cause of the problem. **Y or N**
- Wellness Lifestyle Care - Maintaining the corrections that have been already made. **Y or N**
- Symptom Care - Helping with the symptoms but not changing the overall structure of the spine and there by not fixing the cause of the problem. **Y or N**

Experience with Chiropractic

- Have you been adjusted by a Chiropractor before? **Y or N**
- How long ago was your last adjustment? _____
- Has your spouse or children ever seen a Chiropractor? **Y or N**
- How was your experience with your last Chiropractor? _____

_____

Awareness of Chiropractic Principles

Test Question:

- Doctors of Chiropractic work with the nervous system. True / False
- A healthy body has the ability to heal and self regulate. True / False
- The nervous system is the master system and controller of the body. True / False
- Nerve pressure will affect your body's ability to heal and self regulate True / False
- Nerve pressure will cause poor health and poor function. True / False

Authorization for Care

I hereby authorize Active Life Chiropractic to help my overall health through the use of adjustments to my spine and extremities, as found necessary. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that this office does not bill any medical insurance, including Medicare, on my behalf to pay for any of the service rendered to me. This office does not except Medicare patients, yet if you are eligible for Medicare and desire to be seen by Dr. Smith you can sign a statement that waives your right to bill Medicare. This means you will be completely responsible for the bills occurred in this office and agree that Medicare will not be billed or held responsible for payment. I agree that I am responsible for all bills incurred in this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for services rendered me will become immediately due and payable. There will be no transfer of visits to other persons and No refunds for pre-paid visits. If there is no activity on a pre-paid plan in a twelve month period without prior written notice all visits on that plan will be forfeited. In the event that I am able to receive a reimbursement through the assignment of my insurance (PIP /L&I only), I hereby authorize those insurance rights and benefits payable directly to the provider for services rendered. It is understood and I agreed to have x-rays taken and that the payments to this office for x-ray are for examination and interpretation of x-ray only. The x-ray films will remain the property of this office. They are kept on file where they may be viewed at any time. I agree to the above in its entirety.

Patient/Guardian signature_____Date_____

X-RAY CONSENT FORM

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's signature Date

_____ _____

Active Life Chiropractic

Informed consent for Chiropractic Care

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. It is important that each patient understand both the objective and the method that will be used to attain it.; this will prevent any confusion or disappointment. 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.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

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 usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

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.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent of legal guardian of _____ have

Read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

Gary D. Smith D.C. 1778 Watson St. N. Enumclaw, WA 98022

(360) 825-6009 or (360) 825-BACK FAX (360) 802-0731

activelifechiro@gmail.com

HIPAA NOTICE OF PRIVACY PRACTICES

Active Life Chiropractic
1778 Watson St. N. Enumclaw, WA 98022
360-825-2225

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of 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 protected health information. "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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information
   Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this 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 of disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.**
   Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
2. **You have the right to request a restriction of your protected health information.**
   This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

   Your physician in not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosures of your protected health information, your protected health information will not be restricted. You then have the right to uses another Healthcare Professional.
3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
4. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
5. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

   We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
6. **Complaints**
   You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **March 17, 2011**.

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 protected health information, if you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Sign Name: _____

Date: _____