Family and Sports Chiropractic

300 N. Washington St., Suite 103
Falls Church VA, 22046

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.

This notice takes effect on April 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including preciously created or received before the changes.

Notice of change of privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes the different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific, written authorization. Any specific written authorization you provide may be revoked at any time to us at the address provided.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR APPOINTMENT REMINDERS: We may use and disclose medical information for purposes of sending you appointment notices or calling you to remind you of your appointments.

THIS MAY ALSO INCLUDE COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS; PUBLIC HEALTH ACTIVITIES; VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE; WORKER COMPENSATION; HEALTH OVERSIGHT ACTIVITIES; LAW ENFORCEMENT; ALTERNATIVE AND ADDITIONAL MEDICAL SERVICES.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we will charge you $.25 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information.
4. Request that we communicate with you about your medical information by different means or to different locations, but only if you make your request in writing.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation.
6. ***You have the right to request and obtain a full and complete copy of the Notice of Privacy Practices.***

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, pleases contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice to Family & Sports Chiropractic, 300 N. Washington St., Suite 103, Falls Church VA 22046.

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date _____

Address

_____

City _____ State _____ Zip Code _____ Birth Date _____

Phone Number _____ E-mail _____

Signature _____

CASE HISTORY

Name _____ Date _____
Address _____ City _____State ____ Zip _____
Home Phone _____ Work Phone _____
Date of Birth _____ Age _____ Social Security Number_____
Occupation _____ Employer _____
Marital Status S M D W Number of Children and Ages _____
Spouse's Name _____ Spouse's Occupation _____
Have you ever received Chiropractic Care ☐ Yes ☐ No When _____
Insured _____ Relationship to Patient _____ Insured's Date of Birth _____

About Your Health

The Human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No		Patient Comment If answer is Yes	Chiropractor's Comments
		1. Birth Process		
☐	☐	Was the delivery long?	_____	_____
☐	☐	Was delivery difficult?	_____	_____
☐	☐	Forceps?	_____	_____
☐	☐	Caesarian?	_____	_____
☐	☐	Breach/cephalic?	_____	_____
☐	☐	Hospital Birth?	_____	_____
☐	☐	Mother given drugs during delivery?	_____	_____
☐	☐	Was labor induced?	_____	_____
		2. Growth & Development		
☐	☐	Were you taught how to care for your spine	_____	_____
☐	☐	Did you fall out of bed?	_____	_____
☐	☐	Were you a head banger or a rocker?	_____	_____
☐	☐	Were you breast-fed?	_____	_____
☐	☐	Childhood illnesses?	_____	_____
☐	☐	Accidents?	_____	_____
☐	☐	Surgery?	_____	_____
☐	☐	Drugs?	_____	_____
☐	☐	Did you fall while learning to walk?	_____	_____
☐	☐	Corporal Discipline?	_____	_____
☐	☐	Spanking (how?)	_____	_____
☐	☐	Pulled ear/	_____	_____
☐	☐	Other	_____	_____
☐	☐	Chair pulled out when sat down?	_____	_____
☐	☐	Did you fall down stairs?	_____	_____
☐	☐	Were you yanked by your arm?	_____	_____
☐	☐	Did you have other traumas? What? When?	_____	_____

Yes	No	3. Current Health Habits		
☐	☐	Did/do you smoke?	_____	_____
☐	☐	Did/do you drink any alcohol?	_____	_____
☐	☐	Diet (Do you eat health foods?)	_____	_____
☐	☐	Have you been in any accidents?	_____	_____
☐	☐	Have you had any surgery and organs? removed/replaced?	_____	_____
☐	☐	Drugs (Prescription/non-prescription)	_____	_____
☐	☐	Teeth Problems?	_____	_____
☐	☐	Eye Problems?	_____	_____
☐	☐	Hearing Problems?	_____	_____
☐	☐	Exercise regularly?	_____	_____
☐	☐	Sleeping Habits (nightmares?)	_____	_____
☐	☐	Did/do you have occupational stress?	_____	_____
☐	☐	Physical Stress?	_____	_____
☐	☐	Mental Stress?	_____	_____
☐	☐	Hobbies/sports injuries?	_____	_____
☐	☐	Sleeping posture ☐side ☐ stomach ☐ back	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaints (be brief) _____

Major complaint _____

Pain or problem began on: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of day? _____

Is this condition interfering with work? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other Symptoms:

❑ Headaches	❑ Pins & Needles in Legs	❑ Fainting
❑ Neck Pain	❑ Pins & Needles in Arms	❑ Loss of Smell
❑ Sleeping Problems	❑ Numbness in Fingers	❑ Loss of Taste
❑ Back Pain	❑ Numbness in Toes	❑ Diarrhea
❑ Nervousness	❑ Shortness of Breath	❑ Feet Cold
❑ Tension	❑ Fatigue	❑ Hands Cold
❑ Irritability	❑ Depression	❑ Stomach Upset
❑ Chest Pains	❑ Lights Bother Eyes	❑ Constipation
❑ Dizziness	❑ Loss of Memory	❑ Cold Sweats
❑ Face Flushed	❑ Ears Ring	❑ Loss of Balance
❑ Neck Stiff	❑ Fever	❑ Buzzing in Ears

How long have you been under drug and medical care? _____

What medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of?

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	❑	❑	❑	❑	❑
Mother's Side	❑	❑	❑	❑	❑

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care**, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

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 correction care provided by this office.

RECORDS REMOVAL POLICY
Based on law from the Virginia Board of Medicine Policy:

Original records (files and x-rays/radiographs) may not leave the premises. If requested, X-rays can be copied for a $35 charge per set, files $10 per file and we will inform you of the cost before the request is completed. We will provide a written radiographic report to you at no charge, if requested.

This will take a minimum of five business days, after a request in writing.

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 menses: _____

_____ _____
(Patient's signature) (Date)

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

_____ _____
(Patient's signature) (Date)

FAMILY AND SPORTS CHIROPRACTIC

FINANCIAL AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Family and Sports Chiropractic Inc. 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 the Family and Sports Chiropractic Inc., will be credited to my account on receipt. However, I clearly understand and agree to suspend or terminate any fees for professional services rendered me, will be immediately due and payable. I also understand that if I suspend or terminate any fees for professional services rendered me; will be immediately due and payable. I understand I am responsible to pay interest on overdue balances at the rate of 18% APR and Attorney's fees at 30% of the outstanding balance will be added if my account is sent to collections. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to treat a minor: _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care: _____ Date: _____