Patient Information

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ Date of Birth:_____

Marital Status: □ Married □ Single □ Widowed □ Separated □ Divorced

Employer's Name and Address:_____

_____

Email:_____ How did you hear about us?:_____

If referred, who referred you to our office?:_____

Present Health Condition

In what areas are you experiencing pain or discomfort?:

_____
_____
_____
_____
_____

When did these issues start? (If issues are long term, when was the most recent flare up?):

_____
_____
_____
_____
_____

List anything that makes your pain or discomfort worse:

_____
_____
_____

Do you have any pain, numbness or tingling in the arms or legs?

□Yes □No

Does your pain get better or worse at certain times in the day? If so, when?: _____

_____

Can you think of anything that may have caused your pain or discomfort? ex. lifting heavy groceries, tripping, or falling. _____

_____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

□ Work Activities Effected: _____

Have you missed any days of work? □Yes □No If yes, dates missed:_____

□ Home Activities Effected: _____

□ Recreational Activities Effected: _____

Family Health History

To help your doctor determine if your health problem is hereditary, please fill out the following table on the health of your immediate family members. (Grandparents, Parents or Siblings)

Yes	No	
		Cancer
		Rheumatoid Arthritis
		Epilepsy
		Diabetes
		Chronic Back Problems
		Heart Problems
		Chronic Headaches
		Lung Problems
		High Blood Pressure
		Lupus

Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily:_____ Do you drink? □ Yes □ No If yes, how many drinks/week:_____
Do you exercise regularly? □Yes □ No If yes, describe what type and how often:_____

_____

Do you consider yourself to have a good social support system (friends/family)? □ Yes □ No

Review of Symptoms

Check any symptoms you've had in the past year:

□ Muscle Pain	□ Fever	□ Chills	□ Fatigue	□ Eye pain	□ Blurred vision
□ Double vision	□ Headaches	□ Joint swelling	□ Nosebleed	□ Ringing in ears	□ Chest pain
□ Skin changes	□ Fainting	□ Wheezing	□ Chest tightness	□ Anxiety	□ Heartburn
□ Nausea	□ Vomiting	□ Constipation	□ Diarrhea	□ Bloody stool	□ Joint stiffness
□ Difficult/ painful urination	□ Unexpected weight loss or gain	□ Difficulty swallowing	□ Heart Palpitations	□ Poor wound healing	□ Shortness of breath
□ Depression	□ Tremors	□ Seizures	□ Easy bleeding/ bruising	□ Excessive thirst or urination	□ Allergic Reactions

Previous Health History

Who is your primary care physician/family doctor?: _____
When were you last seen there: _____
May we send them updates on your treatment/condition: □Yes □No

During the last year, has a doctor treated you for any health problem? □Yes □No
If yes, please explain: _____
_____
_____

Have you ever received Chiropractic care? □Yes □No

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____
_____
_____

Please check the prescription drugs you are currently taking: □Anti-depressants □Anti-Inflammatory
□Birth Control Pills □Blood Pressure Medication □Diet Pills □Blood Sugar Medication
□Muscle Relaxers □Insulin □Pain Pills □Sleeping Pills
Other (please list):_____
_____

Please check the over the counter drugs you are using and how much your take:
□Aspirin:_____ □Tylenol:_____ □Ibuprofen:_____ □Other:_____

Financial Responsibility

Who is responsible for your bill? □ Insurance □ My Employer □ Spouse □ I am □ Other
Type of Insurance: □ Automobile □ Health □ Worker's Comp

Insurance Company's Name: _____

If you have a Health Care Payment / Health Savings Account card that you would like us to use for payments, please note the information here: Card number _____
Expiry Date: _____/_____ 3-digit Security Number: _____

By signing on the line below, you agree to the following: Unless other arrangements have been made in advance, your fees are due and payable at the time examination and treatments are received. We will protect your personal health information/records, which you have the right to review and amend. You give consent to Dr. Edward Owens, the billing service and the insurance company to use and/or disclose any personal health information required to process your medical claims, perform any required treatment or perform required administrative operations. We will ask for your written permission for any other disclosure of your personal health information. You authorize your insurance company to pay Chiropractic of Bellevue directly. Any services not covered by your insurance or any other party are the sole responsibility of the patient. This authorization will expire upon permanent dismissal of the patient.

Patient's Signature:_____ Social Security No.:_____ Date: _____

Parent or Guardian Signature (if patient is a minor)

_____ Social Security No.:_____ Date: _____

Chiropractic of Bellevue
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: _____

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Sarah Starkey or Morgan Humphrey, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Chiropractic of Bellevue or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Chiropractic of Bellevue
Sarah Starkey or Morgan Humphrey
Privacy Officer
13400 NE 20 ST, STE 2
(425) 802 5432
(855) 237- 3755

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request.

Chiropractic of Bellevue

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Patient ID #:** _____

I hereby acknowledge that I have received a copy of Chiropractic of Bellevue's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

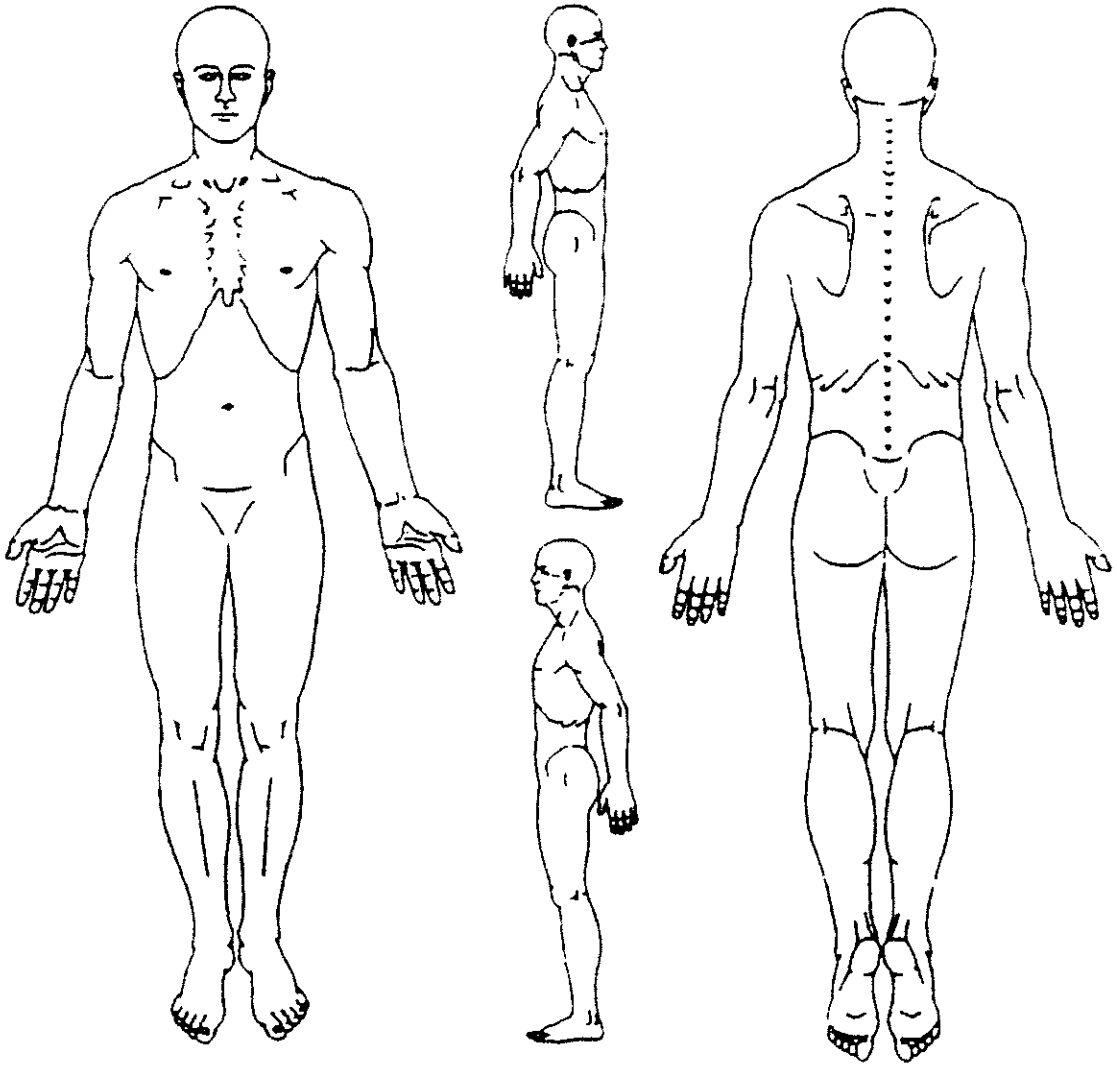
PAIN DRAWING

PATIENT NAME _____ DATE _____

On a scale from 0 – 10, with 10 being unbearable pain, how severe is your pain?

PAIN INTENSITY	None	MILD			MODERATE				SEVERE		
PAIN LEVEL	0	1	2	3	4	5	6	7	8	9	10

ON DRAWING BELOW, CIRCLE AND USE THESE LETTERS TO INDICATE TYPE AND LOCATION OF DISCOMFORT:				
D = DULL	SH = SHARP	A = ACHING	C = CUTTING	CR = CRAMPING
TH = THROBBING	B = BURNING	N = NUMBING	TI = TINGLING	CO = CONSTRICTING
SP = SPASM	ST = STINGING	S = SHOOTING	P = POUNDING	T = TIGHT



DOCTOR USE ONLY:

COMPLAINT	T%: 0 – 25	26 – 50	51 – 75	76 – 100