PATIENT HEALTH QUESTIONNAIRE

Listed below are common diseases and disorders. Please indicate whether you have had in the past or are presently troubled by a listed disorder.

Past	Present	Condition	Past	Present	Condition
❑	❑	Depression	❑	❑	Emphysema (lung disorders)
❑	❑	Aortic aneurysm	❑	❑	Arthritis
❑	❑	High blood pressure	❑	❑	Diabetes
❑	❑	Angina	❑	❑	Ulcer
❑	❑	Heart attack	❑	❑	Kidney stones
❑	❑	Stroke	❑	❑	Bladder infection
❑	❑	Asthma	❑	❑	Kidney disorders
❑	❑	Cancer	❑	❑	Other ______________________
❑	❑	Prostate problems			
❑	❑	Anorexia	❑	❑	Other ______________________

Please check any of the following that apply to you.

Past	Present	Condition	Past	Present	Condition
❑	❑	Pregnancy	❑	❑	Medications; please list
❑	❑	Tobacco use			____________________________
❑	❑	Alcohol use			
❑	❑	Coffee/Tea/Caffeinated drinks			____________________________
❑	❑	Drug or alcohol dependence	❑	❑	Surgical procedures; list
					____________________________
					____________________________

PATIENT LIFESTYLE QUESTIONNAIRE

How would you grade your general stress level?

- ❑ No Stress
- ❑ Minimal Stress
- ❑ Moderate Stress
- ❑ Heavy Stress

How would you rate your level of general physical activity?

- ❑ No regular exercise program
- ❑ Light exercise program
- ❑ Strenuous exercise program

How would you rate your level of activity at work?

- ❑ Sedentary more than 50% of the workday
- ❑ Light manual labor
- ❑ Moderate manual labor
- ❑ Heavy manual labor

Name ___________________________________

Thank you for choosing HealthQuest, Inc.

PATIENT INJURY QUESTIONNAIRE

When did your problem begin?
- ❑ Immediately after a specific incident
- ❑ After multiple incidents
- ❑ Gradually developed over time

Describe how your problem began: ____

____

Have you received any prior treatment for this condition? ❑ No ❑ Yes, please describe: ____

Please check any of the following that you have experienced in the ***past*** and check the ***present*** for the conditions pertaining to your complaints at this time.

Past	***Present***	***Complaint***
❑	❑	Headache
❑	❑	Dizziness
❑	❑	Nervousness
❑	❑	Fainting
❑	❑	Tension
❑	❑	Fatigue
❑	❑	Irritability
❑	❑	Depression
❑	❑	Light bothers eyes
❑	❑	Head seems too heavy
❑	❑	Ringing in ears
❑	❑	Face flushed
❑	❑	Chronic sinusitis
❑	❑	Loss of memory
❑	❑	Loss of balance
❑	❑	Loss of smell
❑	❑	Loss of taste
❑	❑	Loss of appetite
❑	❑	Difficulty swallowing
❑	❑	Chronic cough
❑	❑	Shortness of breath
❑	❑	Heartburn/Indigestion
❑	❑	Fever
❑	❑	Cold sweats
❑	❑	Rapid heartbeat
❑	❑	Sleeping problems
❑	❑	Abnormal weight gain
❑	❑	Abnormal weight loss
❑	❑	Menopausal symptoms
❑	❑	Stomach upset
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Painful urination
❑	❑	Loss of bladder control
❑	❑	Frequent urination

Past	***Present***	***Complaint***
❑	❑	Neck pain
❑	❑	Shoulder pain
❑	❑	Arm pain
❑	❑	Pins & needles in arms
❑	❑	Elbow pain
❑	❑	Hand pain
❑	❑	Pins & needles in hands
❑	❑	Numbness in hands
❑	❑	Cold hands
❑	❑	Mid back pain
❑	❑	Chest pain
❑	❑	Abdominal pain
❑	❑	Lower back pain
❑	❑	Hip pain
❑	❑	Upper leg pain
❑	❑	Lower leg pain
❑	❑	Knee pain
❑	❑	Ankle or foot pain
❑	❑	Numbness in toes
❑	❑	Cold feet
❑	❑	Stiff joints
specify: ______________		
❑	❑	Swelling of joints
specify: ______________		
❑	❑	Rash/Dermatitis/Eczema
specify: ______________		

How are your complaints affecting your ability to work or be active?
- ❑ No effect
- ❑ Need limited assistance with common everyday tasks.
- ❑ Have a significant inability to function without assistance.
- ❑ Some physical restrictions (able to do light duty work and household tasks)
- ❑ Need assistance often.
- ❑ Total disability or impairment, cannot care for myself.

Name ______________________________

PATIENT AGREEMENTS

In consideration of treatment by the doctor the undersigned agrees as follows:

1. To pay the amount charged by the doctor for all professional treatment and services to the undersigned and/or his/her family. Payment is to be made to HealthQuest, Inc.

2. All charges are due and payable at the time of service unless other financial agreements are made.

3. To pay all collection fees, settlement costs and reasonable attorney fees in the event of referral to any collection agency, arbitration or mediation procedure, or suit. I further agree to pay all costs of collection, including a 50% commission.

4. That in the event of death, this obligation shall be binding on the estate, heirs and successors of the undersigned.

5. Any balance due 30 days after treatment will be subject to a 2% per month service charge (APR of 24%)

FINANCIAL ARRANGEMENTS

1. This office will accept payment for services by cash, check, and all major credit cards.

2. This office has financial plans available. A Chiropractic Assistant will discuss this with you upon request. Financial arrangements must be set to paper and signed by both parties to be binding.

CHIROPRACTIC INSURANCE

1. If you have medical insurance that covers chiropractic, your ***estimated*** portion is due and payable at the time of service. If after this office receives payment from the insurance company, a balance remains, a statement will be sent to you. If your insurance is BlueCross BlueShield PPO or ValueCare, full payment is due at time of service as their policy is to pay the insured directly.

2. If an insurance payment is not received within 60 days, the full amount is due and payable by the patient.

3. The filing of a secondary insurance is the patient's responsibility. HealthQuest may assist you with necessary paperwork.

I/We do hereby accept the above agreement. I also give permission for the doctor and/or his designated employees to perform chiropractic services for any minor(s) listed below for whom I/We are responsible.

____

Print patient's name

______________________________________ ______________________________

Patient Signature Date

HIPAA 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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "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.

I. Uses and Disclosures of Protected Health Information

Your PHI 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 PHI 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 PHI, as necessary, to a home health agency that provides care to you or 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 PHI will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your PHI 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, marketing and fundraising activities; and conducting or arranging for other business activities. For example, we may disclose your PHI 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, and we may also call you by name when entering or treating in the clinic. We may use or disclose your PHI, as necessary, to contact you to remind you of appointments.

We may use or disclose your PHI in the following situations without your authorization: as required by law for public health issues; in the case of communicable diseases, abuse, or neglect; health oversight; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; military activity and national security; workers' compensation. 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 or disclosure indicated in the authorization.

Name ____________________________________

Your Rights

Following is a statement of your rights with respect to your PHI.

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 PHI that is subject to law that prohibits access thereto.

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 PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI 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 is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You retain the right to use another health care professional.

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.

You may have the right to have your physician amend your PHI. 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.

You have the right to an accounting of certain disclosures we make of your PHI.

We reserve the right to change the terms of this notice and will inform you in writing of any changes. You then have the right to object or withdraw as provided in this notice.

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 **May 06, 2005.**

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 PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (801) 281-0555.

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

____

Print patient's name

____ __________________________

Patient Signature Date