Northern Nevada
CHIROPRACTIC

Today's Date: _____/_____/_____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

Personal Information:

Name: *(First)*_____ *(Middle)*_____ *(Last)*_____ *Jr.*, II, Ill, IV

Address: _____City:_____ State:_____ Zip: _____

Birth Date:____ /_____/_____ Age:_____ Marital Status: Divorced Married Single Separated Widowed

Gender *(Circle)*: Male/ Female Home Phone: (_____)_____Cell Phone:(_____)_____

Email Address:_____ @_____

Emergency Contact Information

Name:*(First)*_____ *(Middle)*_____ *(Last)*_____ Jr., II, **111,** IV

Address:_____ City:_____ State:_____ Zip:_____

Relationship:_____Home Phone:(_____)_____Cell Phone:(_____)_____

Payment/Insurance Information:

Is the condition(s) that brought you here today due to an automobile accident? Yes No

Is the condition(s) that brought you here today due to an on-the-job/workers compensation injury? Yes No

Is the condition(s) that brought you here today due to any type of accident or trauma? Yes No

Date of the injury: _____

Who besides yourself is responsible for your bill?

- Self-Pay *NO INSURANCE*
- Health Insurance Medicare –
- Attorney: (Name)_____(Firm)_____(Phone Number)_____
- Worker's Comp: (Insurance Name)_____
- Auto Insurance: (Insurance Name)_____
- Other *(Be Specific)*: _____

Insurance Carrier:_____ ID#:_____Group#:_____

Insured Person's Date of Birth:_____/_____/_____

Auto or Workers' Comp Insurance Carrier & Claim #:_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins or terminate my care as a patient during treatment if I am not following the treatment plan for my condition or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment but are part of the process of information.

gathering so that the doctor can determine whether to accept me as a patient.

_____

PATIENT PRINTED NAME

_____

PATIENT SIGNATURE

_____

DATE

PRIMARY COMPLAINT:

When did it start?_____

Describe the condition:_____

What do you think caused the problem? _____

Rate the pain from 1-10:_____At its worst:_____At the present time_____At least severe _____

Does the pain travel? Yes No If yes, from where to where?_____

Is the condition getting worse? Yes No

IMAGING:

X-Ray _____MRI _____Other:_____

Date of Imaging: ___/_____/_____

Name/Address of Facility: (Name)_____ (Address)_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS: _____

_____

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES: _____

_____

_____

_____

_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL: ___

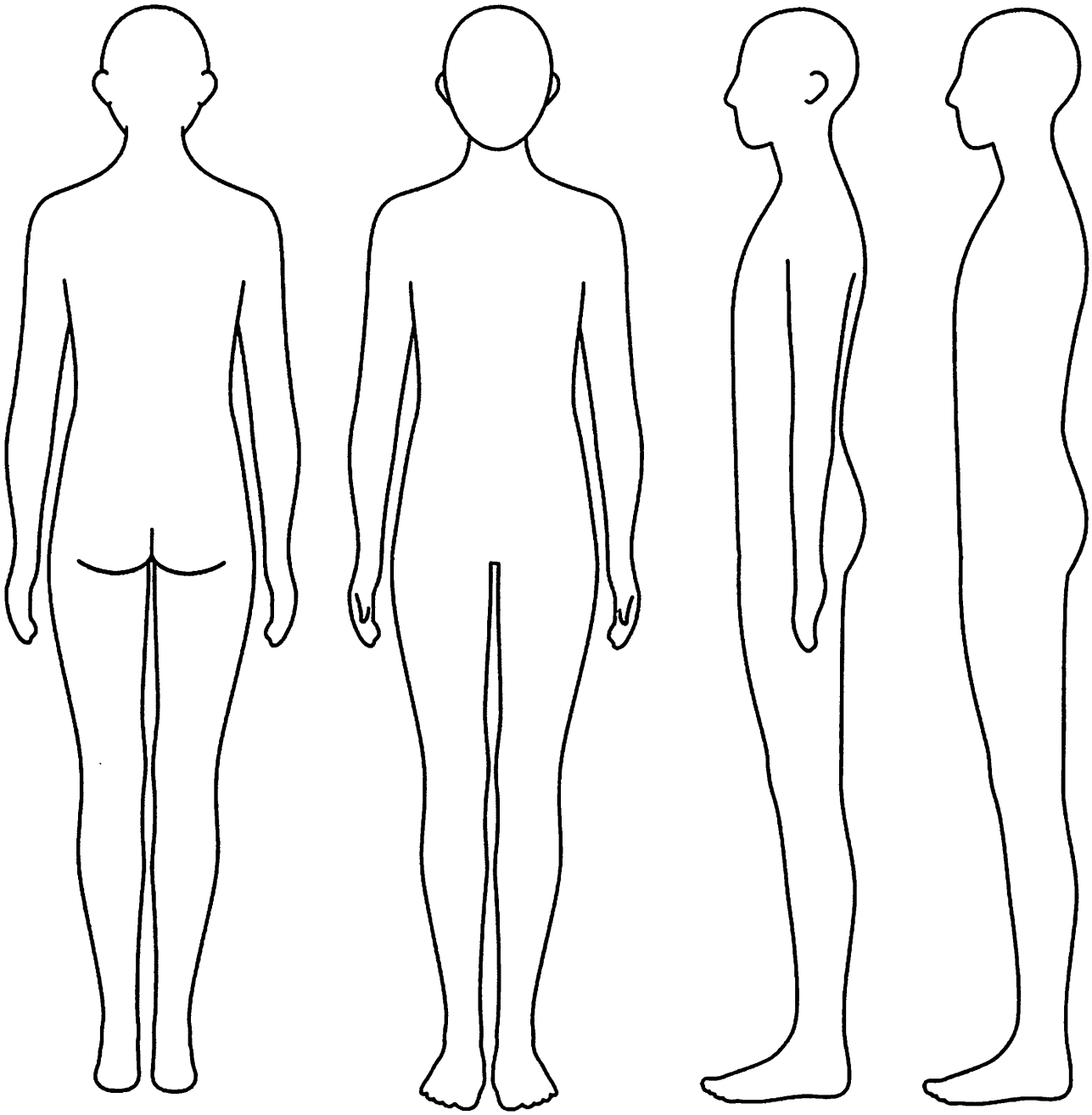
_____

_____

_____

_____

Mark where the pain/problem area is



A= Ache **B= Burning** **N= Numbness**

P= Pins & Needles **S= Stabbing** **O= Other**

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all the sections. If none of the conditions apply, select "None."

Constitutional:
- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching *(around the eyes)*
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:
- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection*(s)*
- Ear Pain
- Fainting
- Head Injury *(history of)*
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Postnasal Drip
- Rhinorrhea *(runny nose)*
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus *(ringing in the ears)*
- TMJ Disorder

Cardiovascular:
- None
- Angina *(chest pain or discomfort)*
- Chest Pain
- Claudication *(leg pain or achiness)*
- Heart Murmur
- Heart Problems
- Orthopnea *(difficulty breathing while lying)*
- Pacemaker
- Palpitations *(irregular or forceful heartbeat)*
- Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- Shortness of Breath
- Swelling of Leg*(s)*
- Ulcers
- Varicose Veins

Gastrointestinal:
- None
- Abdominal Pain
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice *(yellowing of the skin)*
- Nausea
- Vomiting

Respiration:
- None
- Asthma
- Shortness of Breath
- Wheezing

Arthritis:
- None
- Ankylosing Spondylitis
- Osteoarthritis
- Rheumatoid
- ☐ **Other:** _____

Endocrine:
- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- None
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Migraines
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- None
- Anaphylaxis *(history of)*
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:
- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion*(s)*
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- None
- Anhedonia *(inability to experience joy or enjoy life)*
- Anxiety
- Appetite Changes
- Behavioral Change*(s)*
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change*(s)*

Female:
- None
- Birth Control Therapy
- Hormone Therapy
- Irregular/Painful Menstruation
- Pregnant
- Breast Feeding

Male:
- None
- Burning Urination
- Erectile Dysfunction
- Prostate Problems

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ Doctor Signature _____ Date

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click' sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, exercise instruction, spinal decompression therapy etc.

Cerebral Vascular Issues: Cerebral Vascular issue is the most serious problem that has been associated with chiropractic adjustments and means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. In extremely rare instances chiropractic adjustments have been associated with Cerebral Vascular issues that arise from the vertebral artery only; this is because the vertebral artery is found inside the neck vertebrae. Certain types of neck adjustments may potentially be related to vertebral artery issues, but no one is certain. The most recent studies (Journal of the CCA, vol. 37, June 1993) estimate that the incident of a Cerebral Vascular issue is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, spinal decompression therapy etc. This includes both neck and back. Yet occasionally chiropractic treatment (adjustments, traction, spinal decompression therapy etc.) will aggravate the problem and surgery may rarely become necessary for correction. Rarely chiropractic adjustments may also cause worsening of a pre-existing disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their problem.

Dry Needling: The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization. Other risks may include bruising, infection, or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely.

Soft tissue injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments, traction, massage therapy, spinal decompression therapy etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments of resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical therapy burns: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone's skin has a different sensitivity to these modalities, and rarely either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercises, spinal decompression therapy etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition because of treatment at this office. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation

If you have any questions on the above, please ask your doctor during your appointment. If you wish to talk to him prior to signing, then please let the front desk staff know. When you have a full understanding, please sign and date below.

I hereby request and consent to the performance of Chiropractic adjustments and other procedures/modalities in office, including various modes of physical therapy, spinal decompression and diagnostic x-rays on me by the doctor of Chiropractic and or other doctors of Chiropractic who now and in the future treat me while employed by, work, or associate with serving as back-up for the doctor of Chiropractic, including those working at this clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent. And by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

Name _____ Date _____

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE) – Page 1

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

You can ask us **NOT** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious/imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact information: (name), (email)

Effective Date of Notice: (date)

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:

1) May we confirm your appointments by email, text or phone?	Yes	No
2) May we leave a message on your answering device at home or cell phone?	Yes	No
3) May we discuss your condition with any members of your family?	Yes	No
If yes, provide names: _____		
4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room?	Yes	No
5) May we text you statements/payment requests?	Yes	No
6) May we keep a card on file for payments?	Yes	No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ Patient Printed Name

_____ Patient Signature or legal representative

_____ Date

_____ If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____ Name of patient

_____ Name of staff member

_____ Signature of staff member

_____ Date