Back In Balance Chiropractic, LLC

Confidential Patient Information

Date_____

Name _____Home Phone (____)_____-_____Cell (____)_____-_____

Address_____ City_____ State_____ Zip Code_____

E-mail_____Employer_____Work phone_____

Date of Birth_____/____/____ Sex M F Marital Status: _____ Height ____ft. ____in Weight _____lbs.

Spouse's Name_____ Spouse's Employer_____

Who referred you to our office? _____ Who is your Family Dr._____

Is your visit due to an auto/work related accident? □ No □ Yes (if yes, please ask for an injury report)

YOUR PRESENT COMPLAINT_____

BRIEFLY DESCRIBE YOUR SYMPTOMS_____

_____

List other doctor(s) seen for this condition _____

Medical history (if any of the following are relevant to your medical history, please check accompanying box:)

□ Cancer	□ Muscular Dystrophy	□ Rheumatic Fever	□ Digestive Disorders
□ Polio	□ Multiple sclerosis	□ Scarlet Fever	□ Sinus trouble
□ Tuberculosis	□ Convulsions	□ Nervousness	□ Backaches
□ High Blood Pressure	□ Epilepsy	□ Asthma	□ Numbness
□ Heart Trouble	□ Concussion	□ Dizziness	□ Arthritis
□ Diabetes	□ Hepatitis	□ German Measles	□ Venereal Disease

Describe any operations you've had and the dates:_____

_____

Have you been treated by a physician for any health condition in the last year? □ Yes □ No

Describe Condition_____ Date of last physical_____

Are you now taking any medication? □ Yes □ No. What kind?_____

Are you allergic to any medication? □ Yes □ No. What kind?_____

WOMEN ONLY: Are you pregnant? □ Yes □ No Date of last menstrual period: _____

PLEASE SUBMIT YOUR INSURANCE CARD WITH YOUR PAPERWORK TO ENSURE ACCURATE FILING

Do you have insurance? □ yes □ no Company_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctors at Back In Balance Chiropractic, LLC and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Name: _____ Date: _____

The Nature of Chiropractic Treatment: The doctor will use his/ her hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop”, and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, massage, electrical muscle stimulation, ultrasound, traction or therapeutic activities may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bones, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered “rare.”

Other Treatment Options Which Could Be Considered May Include the Following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable diseases in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

Printed Name Signature

Back In Balance Chiropractic, LLC HIPPA Notice

Please review and sign our office policy regarding your confidential information:

In the course of your care as a patient at Back In Balance Chiropractic, LLC, we may use or disclose personal and health related information about you in the following ways:

*Your protected health information and clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care and billing records may be disclosed to another party, such as an insurance carrier or your employer, if they may be responsible for the payment of services provided to you.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
* If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information to you in person, but you may receive mail regarding your health care or about the status of your account. If you would like to receive this information at a different address or in a different form please advise us in writing as to your preferences. You have the right to inspect, copy, or request an amendment to your health information as long as the information remains in our files. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests require the agreement of this office. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will be unaffected by this office or our staff in any way.

This notice is effective as of July 1, 2005. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and understand this notice.

_____ _____ _____

Name (Printed please) Signature (of patient or legal guardian) Date