Welcome to Our Office!

Please provide us with <u>all</u> of the requested information sothat we may serve you to the best of our ability.

Name: _____ Nickname: _____ DOB: ___ /___ /___

Address:_____
Street City State Zip

Best Phone Number to Reach You: _____□*home*□*cell* □*work*

Marital Status: *S M D W**Spouse's name:*** _____

Do you have any children?□ *Yes* □ *No*
Names and Ages:_____

Employer: _____Brief Job Description: _____

Whom may we thank for your referral? /How did you hear about us?
□***Referred by:*** _____ □ *Search Engine* □ *Insurance Provider List*
(Name)
□ *Wellness Fair*□ *Dr.'s Lecture*□ *Signage* □ *Advertisement*□ *Employee Appreciation Day*

We send important notices such as severe weather closings, holiday hours, and monthly newsletters via email. **Email: _____**

<u>We recommendAutomaticAppointment Reminders via text message or email;</u>

Which would you prefer? □ *Email* □*Text: <u>Cell Phone Provider:</u>*_____

How far in advance would you like your appointment reminder?
□*30 minutes* □ *2 hours*□*4 hours*□*1 day*

Have you ever been to a chiropractor?
□ *No* □*Yes* ***On what date were you last adjusted?***_____

What are your goals for your care with us?
Please check all that apply:

□ *feel better*	□ *move better*	□ *reduce irritability*	□ *improve balance*
□ *stay well*	□ *peace of mind*	□ *breathe better*	□ *get pregnant*
□ *improve sleep*	□ *improve focus*	□ *reduce stress*	□ *improve mood*
□ *improve health*	□ *improve energy*	□ *improve fertility*	□ *easier pregnancy*
□ *more relaxed*	□ *reduce depression*	□ *reduce dependency on pharmaceuticals*	
□ *improve immunity*	□ *learn more about chiropractic*	□ *other:* _____	

Have you experienced difficulties with any of the following systems or conditions? Please check all that apply:

□ *cardiovascular*	□ *vision*	□ *difficulty hearing*	□ *paralysis*
□ *musculoskeletal*	□ *dental*	□ *dizziness*	□ *nausea*
□ *respiratory*	□ *digestive*	□ *cancer*	□ *cold extremities*
□ *skin conditions*	□ *diabetes*	□ *excessive thirst*	□ *stroke*
□ *hormonal*	□ *epilepsy*	□ *excessive appetite*	□ *ear pain/infections*
□ *lymphatic*	□ *abnormal BP*	□ *poor appetite*	□ *unexpected weight loss*
□ *immunity*	□ *chest pain*	□ *progressive headaches*	□ *other:* _____

Please markareas of concern on the diagram:

Briefly describe your chief complaint if applicable:

What's wrong?

_____

_____

How does it feel?

_____

_____

How long has it been happening?

_____

_____

How often do you notice it?

_____

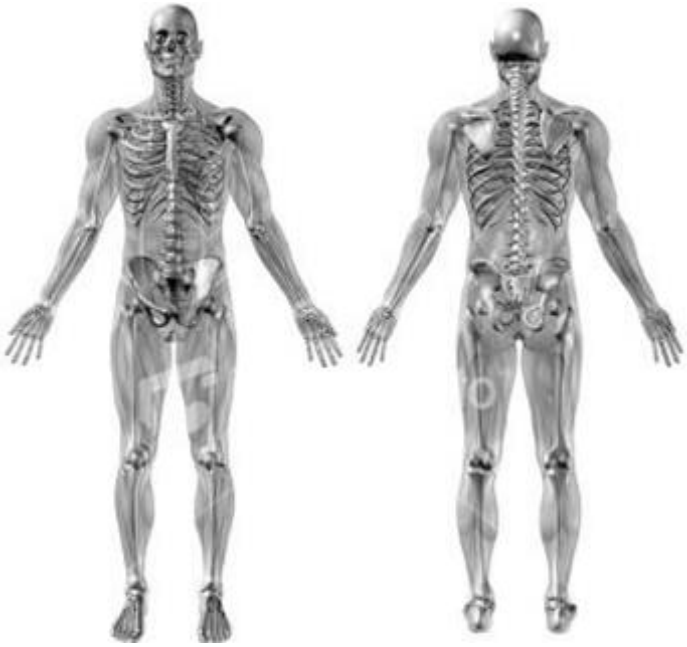
_____

What makes it better?

_____

What makes it worse?

_____



Do you know that irritation of your spinal nerves can cause your body to malfunction? □ Yes □ No

Do you know that chiropractic care reduces and prevents spinal nerve and spinal cord irritation? □ Yes □ No

Do you know that spinal nerve and spinal cord pressure usually occur<u>without</u> pain? □ Yes □ No

Do you know that spinal nerve irritation is most commonly caused by "subluxations" a misalignment of vertebrae that puts pressure on your spinal nerves and spinal cord? □ Yes □ No

Subluxations are caused by: Physical Trauma, Negative Thought, and Toxins.

Which of the following stressors have you ever encountered?

Physical Trauma:

☑ *being born*	□ *contactsports*	□ *dislocations*	□ *fights*
☑ *learning how to walk*	□ *broken bones*	□ *slips/falls*	□ *knocked unconscious*
□ *prolonged sitting at computer*	□ *head injury*	□ *motor vehicle accident*	□ *overweight*
□ *use (d) cane, walker, or crutches*	□ *heavy lifting*	□ *driving long hours*	□ *concussion*

Please describe any surgeries, accidents, or injuries:

_____

Negative Thought in Excess:

□ *sadness*	□ *anxiety*	□ *low self-esteem*	□ *caring for others*
□ *difficult relationships*	□ *worry*	□ *grief*	□ *deadlines*
□ *fear*	□ *financial stress*	□ *anger*	□ *disappointment*
□ *stressful employment*	□ *divorce*	□ *concern about loved one*	□ *guilt*

Please describe any significant emotional crisis in your life time:

_____

Toxins:

□ *pesticides*	□ *prescription drugs*	□ *alcohol*	□ *tobacco*
□ *caffeine*	☑ *air pollution*	□ *over the counter pharmaceuticals*	□ *vaccines*
□ *artificial sweeteners/sugar*	□ *recreational drugs*	□ *preservatives/processed foods*	☑ *water pollution*

Describe any medications you are currently taking:

_____

My biggest concern(s) about Chiropractic care are:

□ *Money*	□ *Trust*
□ *Time*	□ *Apprehension*
□ *Skepticism*	□ *Not worried*

Do you have health insurance? □ Yes □ No**If yes, please bring your card to the receptionist.*

Do you have a Health Reimbursement/Savings account? □ Yes □ No

Please allow the receptionist to take your photo for security purposes.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____

HIPAA Notice of Privacy Practices

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

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and care 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.

Care: We will use and disclose your protected health information 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 protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided 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 protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information 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, and conducting or arranging for other business activities. For example, we may disclose your protected health information 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 indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: 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.

Your Rights: Following is a statement of your rights with respect to your protected health information.

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 protected health information that is subject to law that prohibits access to protected health information.

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 protected health information for the purposes of care, payment or healthcare operations. You may also request that any part of your protected health information 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare 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 protected health information. 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 receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail 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 April 14, 2003.

Our standard operating procedure is open room. We have a private room available upon request.

I authorize Reilly Family Chiropractic, LLC and it's agents to give information regarding my care at Reilly Family Chiropractic, LLC to family members, work associates or others over the telephone. I also authorized Reilly Family Chiropractic, LLC and it's agents to leave information regarding my care on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your care and appointment times. 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 protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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

PRINT NAME:_____SIGNATURE: _____ DATE _____