Personal Client Profile

Welcome to the **Back to Basic Health Chiropractic Center**. We want to make your appointment with us as pleasant and comfortable as possible, so please take your time and fill out the questionnaire as completely as possible. If at any time you have questions regarding your visit, please let us know. All information will remain completely confidential and is only used to help assure the best possible outcome.

Name ____ Date _____________
Address ____
City ______________________________ State ________ Zip ____________________
Home Number ______________________ Work Number ___________________________
Date of Birth ________________________ Social Security Number __________________
Email Address: ____

Referred by: ________________________________

Tell us about the quality of your health:

What brought you to Back to Basic Health Chiropractic Center?

What are your goals for better health?

Have you ever experienced the benefits of alternative health care methods or alternative health care products?

Do you have any health problems or concerns?

List any prescription medications you are currently taking:

What would you like to gain from your experience Back to Basic Chiropractic Center?

How can we help you to best attain your desires for better health?

First consultation date: __________________________ Provider:

PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Name ____ Date ___________

Address ____

City ______________________________ State_________ Zip ____________________

Home Number _____________________ Work Number _________________________

Date of Birth ________________________ Social Security Number __________________

Email Address____ _______________

EMERGENCY CONTACT: ______________ PHONE NO. _______________________

IF COVERED BY INSURANCE, PLEASE FILL OUT THE FOLLOWING INFORMATION: (MAJOR MEDICAL, MEDICARE OR AUTO. PLEASE PROVIDE CARD FOR COPY AT FRONT DESK)

PRIMARY INSURANCE COMPANY: ____

NAME **OF INSURED:** ____________________ **INSURED SOCIAL SECURITY #**____________

ID # OR SUBSCRIBER # __________________ **POLICY #** _____________ **GROUP#**_______

SECONDARY INSURANCE COMPANY: _____________________________________

ID OR SUBSCRIBER # ____________________ **POLICY #** ______________ **GROUP#**______

PLEASE NOTE THAT WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY ONLY. IF INSURANCE DOES NOT COVER/PAY FOR SERVICES RENDERED THE RESPONSIBILITY OF PAYMENT IS YOURS.

LIST ALL CURRENT HEALTH PROBLEMS/CONCERNS:

LIST ANY DOCTORS/FACILITIES SEEN **FOR CURRENT HEALTH PROBLEMS:**

CAUSE /DATE OF INJURY:

SYMPTOMS:

LIST OTHER TRAUMAS/ACCIDENTS/SURGERIES AND DATES:

WITH MY SIGNATURE I HEREBY STATE THAT ALL INFORMATION IS TRUTHFUL AND ACCURATE. I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

PATIENT SIGNATURE ________________________________ **DATE** ________

HEALTH CHECK LIST

PLEASE CHECK ALL THAT APPLY

__SWELLING IN JOINTS
__AREAS OF SWELLING
__AREAS OF NUMBNESS
__AREAS OF SORENESS
__COLD FEET/HANDS
__ARTHRITIS
__JOINT PAIN
__DIZZINESS
__SHORTNESS OF BREATH
__CHEST PAIN
__HIGH BLOOD PRESSURE
__HEART ATTACK
__FAINTING
__MUSCLE PAIN
__ DIABETES
__FIBROMYALGIA
__ MIGRAINES
__HEADACHES
__CHRONIC FATIGUE
__DEPRESSION
__IRRITABILITY
__INDIGESTION
__POOR APPETITE
__NAUSEA/VOMITING
__DIARRHEA
__CONSTIPATIO
__HEMORRHOIDS JAUNDICE
__ABDOMINAL PAIN
__IRREGULAR PERIODS
__ENDOMETRIOSIS

__ FREQUENT COLDS
__ SINUSITIS
__ALLERGIES
__ LOSS OF HEARING
__ VERTIGO
__RINGING IN EARS
__IMPAIRED VISION
__DOUBLE VISION
__SMOKER
__DIPPING
__ALCHOHOL USE
__+5 ALCHOHOLIC BEV/DAY
__SEVERE STRESS
__ MODERATE STRESS
__OVER WEIGHT
__WEIGHT PROBLEM
__ VAGINAL DELIVERIES
__C- SECTION DELIVERIES
__PROBLEMS URINATING
__BLADDER CONTROL
__CHRONIC COUGH
__HIGH CHOLESTERAL
__LACK OF ENERGY
__LACK OF FOCUS
__LACK OF SLEEP
__HOT FLASHES
__ MENOPAUSE
__HORMONE REPLACEMENT
__INSOMNIA
__MOOD SWINGS
__CIRCULATION PROBLEMS

LIST ALL MEDICATIONS FOR ANYTHING CHECKED ABOVE:

DO YOU TAKE ANY OF THE FOLLOWING:

__DAILY VITAMINS

__ANTIOXIDANTS

DOCTORS NOTES:

____

____

____

AGREEMENT FOR SERVICES
AUTHORIZATIONS AND RELEASES
ASSIGNMENT OF BENEFITS

CONSENT FOR TREATMENT:
I, THE UNDERSIGNED, HEREBY AUTHORIZE DR.______________________AND ASSISTANTS TO PERFORM DIAGNOSTIC TESTS INCLUDING BUT NOT LIMITED TO RADIOGRAPHS AND TO ADMINISTER TREATMENT IF NECESSARY. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO THE RESULTS THAT MAY BY OBTAINED. 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 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 I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE ____________________________________ **DATE** ____________________

MEDICAL RELEASE AUTHORIZATION
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S). I ENCOURAGE COLLECTION FOR MY SERVICES RENEDERED IN THIS OFFICE AND ALSO CERTIFY THAT ALL INSLURANCE INFORMATION GIVEN TO THIS CENTER IS CORRECT AND COMPLETE.

PATIENT SIGNATURE ____________________________________ **DATE** __________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER
POWER OF ATTORNEY

I HERBY AUTHORIZE THE ____________________________ INSURANCE COMPANY AND/OR INSURANCE ADMINISTATOR TO PUT DR.____________________ NAME AND BUSINESS ON ANY SETTLEMENT PROCEEDS/CHECK FOR SERVICES RENDERED AND TO MAIL PAYMENT DIRECTLY TO THE DOCTOR/FACILITY FOR PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES. I ALSO AGREE TO PAY ANY BALANCE OF SAID APPLICABLE CHARGES REMAINING FOR THESE SERVICES. I AGREE THAT THIS OFFICE BE GIVEN POWER OF ATTORNEY TO ENDORSE/SIGN MY NAME ON ANY AND ALL DRAFTS FOR PAYMENT OF MY BILL.

PATIENT SIGNATURE ___________________ **DATE** _____________

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE
I, THE UNDERSIGNED AM DIRECTING MY ATTORNEY___________________________TO PAY ANY OUTSTANDING BILLS OUT OF MY SETTLEMENT CONTAINED TO BE IRREVOCABLE. I FULLY UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE FOR ALL MEDICAL BELLS AND THIS AGREEMENT IS MADE SOLEY FOR THE DOCTOR'S ADDITIONAL PROTECTION AND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY RECOVER SAID FEE. I HAVE BEEN ADVISED THAT IF MY ATTORNEY DOES NOT WISH TO COOPERATE IN PROTECTING THE DOCTOR'S INTEREST, THE DOCTOR WILL NOT AWAIT PAYMENT, BUT WILL REQUIRE ME TO MAKE PAYMENT(S) ON THE CURRENT STATUS OF MY BILL UNTIL BALANCE IS PAID IN FULL.

PATIENT SIGNATURE ______________________________ **DATE** _________________

NOTICE OF HEALTH INFORMATION 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.

Back to Basic Health Chiropractic Center is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. Our facility will not use or disclose your health information except as described in this notice. This notice applies to all of the medical records generated within, as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: with your consent, Back to Basic Health Chiropractic Center may use and disclose your health information for the following purposes;

TREATMENT from Back to Basic Health Chiropractic Center may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your attending physician, consulting physician(s), nurses, technicians, medical student, and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. Back to Basic Health Chiropractic Center may also disclose your health information to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, clergy and others used to provide services that are part of your care. Other ways we may use or disclose your health information for purposes related to treatment are:

- **Treatment Alternatives: To tell you about or recommend possible treatment options or alternatives that may be of interest to you.**
- **Appointment Reminders: To contact you as a reminder that you have an appointment for treatment or medical care at Back to Basic Health Chiropractic Center.**
- **Payment: Back To Basic Health Chiropractic Center may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement for services rendered. The information may be released to an insurance company 7, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account For example, a bill sent to a third party payer may include information to other care providers who have been involved in your care, e.g., an ambulance company.**

ROUTINE HEALTHCARE OPERATIONS: Back To Basic Health Chiropractic Center may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of Back to Basic Health Chiropractic Center medical research and educational purposes. Back to Basic Health Chiropractic Center may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of Back to Basic Health Chiropractic Center. Back to Basic Health Chiropractic Center may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on Back to Basic Health Chiropractic Center's behalf. Examples of business associates, include, but are not limited to, a copy service used by to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. Back to Basic Health Chiropractic Center requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: Back to Basic Health Chiropractic Center may not disclose your health information to persons outside of the Practice for purposes other than treatment, payment or healthcare operations without your authorization. In addition, Back To Basic Health Chiropractic Center may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to Back to Basic Health Chiropractic Center.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT: Family/Friends: Back to Basic Health Chiropractic Center may disclose your health information to a friend of family member who is involved in your medical care. We may also give information to someone who helps pay for your care. (We may also tell your family or friends of your condition and that you are in the hospital.) In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your health information in this manner, please let us know.

USES AND DISCLOSURES THAT ARE REQUDUED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION:

RESEARCH: Under certain circumstances, Back to Basic Health Chiropractic Center may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent; there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: Back to Basic Health Chiropractic Center may disclose your health information to government and certain private health oversight agencies, e.g. the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGAITON: Back to Basic Health Chiropractic Center may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law Back to Basic Health Chiropractic Center may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, Back to Basic Health Chiropractic Center is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome (AIDS), to the Department of Public Health and Environment to protect the health and well-being of the general public.

WORKER'S COMPENSATION: Back to Basic Health Chiropractic Center may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: Back to Basic Health Chiropractic Center may disclose your health information as required by military command authorities if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: Back to Basic Health Chiropractic Center will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at Back to Basic Health Chiropractic Center are the property of Back to Basic Health Chiropractic Center you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request that the {Practice} only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your physician or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the staff at Back to Basic Health Chiropractic Center at 770-425-0909.

BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with Back to Basic Health Chiropractic Center or with the Secretary of the Department of Health and Human Services. To file a complaint with Back to Basic Health Chiropractic Center, please contact: Dr. Kim Vaccaro at 678-494-6735. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: Back to Basic Health Chiropractic Center will abide by the terms of the Notice currently in effect Back to Basic Health Chiropractic Center reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. Back to Basic Health Chiropractic Center will mail any revised Notice to the address indicated on the [General Admission Agreement] [Patient Information Forms] or such other address you may provide to us from time to time.

NOTICE EFFECTIVE DATE: The effective date of the Notice is 1 September 2004.

I HAVE READ AND FULLY UNDERSTAND THESE TERMS AND AGREMENTS PROVIDED FOR MY PROTECTION.

SIGNATURE____DATE _________________