

Summit Chiropractic & Rehabilitation
New Patient Registration & History

PATIENT INFORMATION

Name _____
Last First MI

Street Address _____

City State Zip

Home # _____ Cell _____

Birthdate _____ Age _____ Sex: M / F

SS# _____ Marital Status: S / M / D / W

Spouse Name _____

Who may we thank for referring you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home # _____ Work # _____

EMPLOYMENT

Work Status: Employed / Student / Retired / Other _____

Occupation _____ Employer _____

Address _____ Wk# _____

INSURANCE Please show insurance card to the front desk

Subscriber's Name _____

Relationship to patient _____

Subscriber's Birthdate ___ / ___ / ___ SS# _____

Ins Carrier _____

Policy# _____ Group# _____

Is patient covered by additional Insurance? Yes / No (circle)

Subscriber's Name _____

Relationship to patient _____

Subscriber's Birthdate ___ / ___ / ___ SS# _____

Ins Carrier _____

Policy# _____ Group# _____

CURRENT PROBLEM HISTORY

Reason for visit _____

When did your symptoms begin? _____

Is this condition getting progressively worse? Y / N / Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): ___ / 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Cramps Tingling Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come-and-go? _____

Does problem interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Lying Down

ACCIDENT INFORMATION

Is condition due to an accident? Y / N

Date of Accident _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Ins Employer Worker Comp. Other

PAYMENT AND ASSIGNMENT & RELEASE

We require payment in full on your first visit at Summit Chiropractic & Rehabilitation, *PLLC*. (SCR). Payment arrangements may be made in advance, if necessary. All insurance payments received will be credited to your account to cover any existing balance. If your balance is zero we will refund the insurance payment to you. Your insurance policy is a contract between you and your insurance company. If you have any questions about their coverage or amounts paid, you should contact them directly. Any balance you have at our office is your responsibility.

I hereby authorize insurance benefits to be paid directly to SCR. I also authorize SCR to release any information to any insurance company, its representative or any attorney regarding care received at SCR.

I acknowledge that I have read and fully understand the above statements regarding payment policies at SCR. I agree to pay all costs and expenses incurred, including attorney fees, should this account be turned over for collection.

Signature of Patient, Parent, Guardian or Personal Representative

Printed name of Patient, Parent, Guardian or Personal Representative

Date

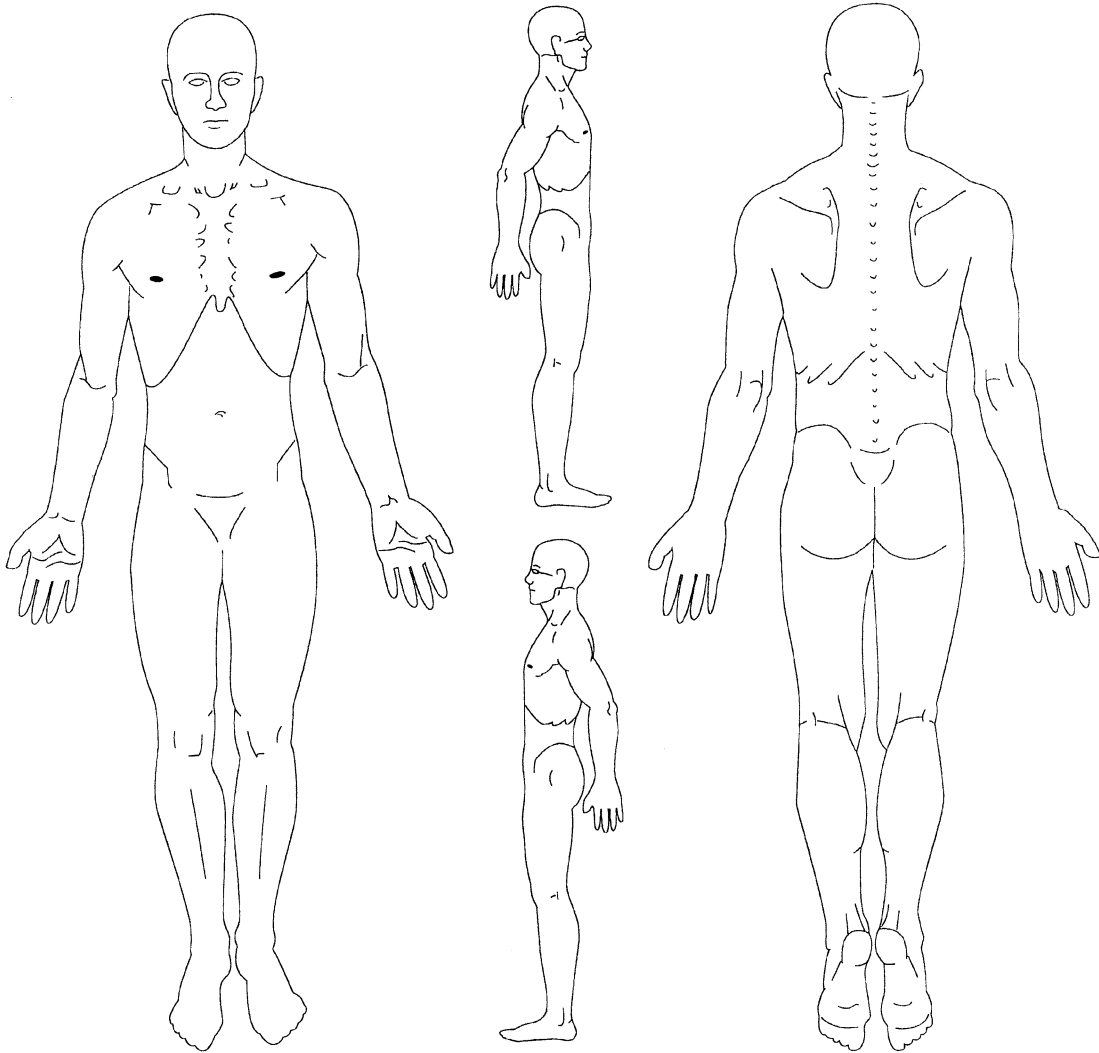
Relationship to Patient

Summit Chiropractic & Rehabilitation

Patient Name (Print): _____ Date: _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain.

- D = Dull
- B = Burning
- N = Numb
- S = Stabbing/Cutting
- T = Tingling (Pins & Needles)
- C = Cramping

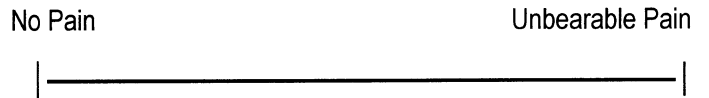


On the scales below, please draw a vertical line representing your pain or discomfort:

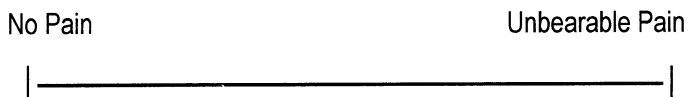
Rate the pain that you have right **NOW**:



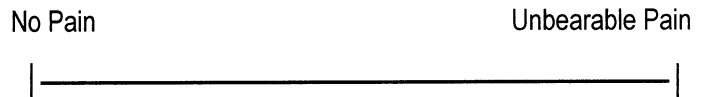
Rate your pain at its **BEST** in the past week:



Rate your **AVERAGE** pain in the past week:



Rate your **WORST** pain in the past week:



HEALTH HISTORY

Name _____

Date _____

1. What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic None Other _____

2. Name & Address of other doctor(s) who have treated you for your condition _____

3. Date of Last: Physical Exam _____ Spinal Xray _____ Blood Test _____
 Spinal Exam _____ Chest Xray _____ Urine Test _____
 Dental Xray _____ MRI, CT-Scan, Bone Scan _____

4. Place a mark on "Yes" or "No" to indicate you have had any of the following:

- | | | |
|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheum Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependnt <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Mult Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | OTHER _____ |
| Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

| EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy | WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor | HABITS <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Wk _____ <input type="checkbox"/> Coffee/Caffeine Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____ | | | | | | | | | | | | | | | | | | |
|---|---|---|----------------------|-------------|------|-------|--|--|---------------|--|--|--------------|--|--|--------------|--|--|-----------|--|--|
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%; padding: 5px;">INJURIES / SURGERIES</th> <th style="width: 20%; padding: 5px;">Description</th> <th style="width: 20%; padding: 5px;">Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Falls</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 5px;">Head Injuries</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 5px;">Broken Bones</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 5px;">Dislocations</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 5px;">Surgeries</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | | | INJURIES / SURGERIES | Description | Date | Falls | | | Head Injuries | | | Broken Bones | | | Dislocations | | | Surgeries | | |
| INJURIES / SURGERIES | Description | Date | | | | | | | | | | | | | | | | | | |
| Falls | | | | | | | | | | | | | | | | | | | | |
| Head Injuries | | | | | | | | | | | | | | | | | | | | |
| Broken Bones | | | | | | | | | | | | | | | | | | | | |
| Dislocations | | | | | | | | | | | | | | | | | | | | |
| Surgeries | | | | | | | | | | | | | | | | | | | | |
| MEDICATIONS | ALLERGIES | VITAMINS / HERBS / MINERALS | | | | | | | | | | | | | | | | | | |
| _____ _____ Pharmacy _____ | _____ _____ _____ | _____ _____ _____ | | | | | | | | | | | | | | | | | | |

| Doctor's Use Only – Health Hx Notes |
|-------------------------------------|
| |

Informed Consent to Treatment

CONSENT TO TREATMENT OF A MINOR CHILD

I authorize the licensed doctor to administer chiropractic care as deemed necessary to my

(Relationship) _____ Name _____

Parent / Guardian Initials _____

FEMALE PATIENTS

This is to certify that to the best of my knowledge I am not pregnant and that Summit Chiropractic & Rehabilitation has my permission to request x-rays.

Beginning date of your last menstrual period: _____

I understand that some herbs may be inappropriate during pregnancy. If I become pregnant, I will inform the doctor.

Pt. Initials _____

PATIENT'S RIGHTS

Summit Chiropractic & Rehabilitation respects the unique differences of our patient, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patient's behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from his/her physician relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the physician and office staff involved in their care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the physician of available and realistic patient care options.
8. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts.

Pt. Initials _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic manipulation, other procedures and methods of treatment including, but not limited to, various modes of physical therapy, diagnostic x-rays, nutritional therapy, and/or tests by Summit Chiropractic & Rehabilitation and their staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the physician and/or with other clinic personnel the nature and purpose of treatment indicated. I will inform the doctor if I experience any gastro-intestinal upset or allergic reaction to the nutritional supplementation therapy. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for the future conditions for which I seek treatment by this clinic and/or employed staff.

Pt. Initials _____

SIGNATURE _____ Printed Name _____ Date _____

WITNESS _____ Printed Name _____ Date _____

Summit Chiropractic & Rehabilitation
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

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 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 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, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information by using a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your appointment time. We may also call you by name in the waiting room when the 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 Disease: 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 and 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: The 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 treatment, 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 purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the 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 Provider.

You have the right to request to receive a 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 and 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 you 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 became effective on **April 14, 2003.**

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: _____