Confidential Patient Information

Name_____Home Phone_____Work_____

Address_____ City_____State_____Zip_____

Date of Birth_____ Marital Status (Circle) M S D W Age _____

Social Security Number _____ E-mail Address_____

Occupation_____ Employer_____

Work Address_____ City,St,Zip_____

Spouse's Name_____# Children_____

Who may we thank for referring you to our office?_____

Have you ever had Chiropractic before? Yes ☐ No ☐ Date_____

Is this injury or illness related to: Employment ☐ Auto Accident ☐

Date:_____ Location:_____

Workers Compensation Ins. Co._____ Phone_____

Your Auto Insurance Co. _____ Phone_____

Third Party Auto Insurance Co. _____ Phone_____

Do You have Health Insurance Yes ☐ No ☐ Subscribers Soc. Sec. #_____

Primary Insurance Company_____ Phone_____

Secondary Insurance Company_____ Phone_____

All Charges are due when services are rendered . . . . . .

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE
Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

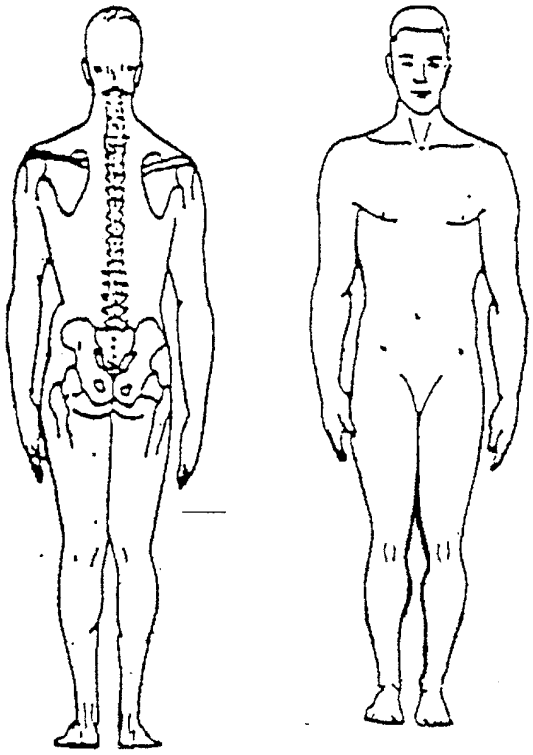
I authorize Lark Family Chiropractic Center to render necessary services to me and I am responsible for all charges incurred.

Patient Signature_____ Date_____

Guardian or spouse's authorizing care _____

Thank You For Allowing Us To Serve You!

*PLEASE MARK AN **X** ON THE DIAGRAM WHERE YOUR PROBLEMS ARE*



What hurts and how long has it hurt?

_____
_____
_____
_____

List your chief complaints in order of severity

1._____
2._____
3._____
4._____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

_____
_____
_____
_____

Check any of the following you have had in the last six months:

	Headaches		Numbness
	Sinus Congestion / Allergies		Frequent Nausea / Vomiting
	Vision Problems		Abdominal Cramps
	Ear aches		Constipation
	Dizziness		Diarrhea
	Heart Problems		Poor / Excessive Appetite
	Lung Problems / Congestion		Excessive Thirst
	Blood Pressure Problems		Painful / Excessive Urination
	Ankle Swelling		Discolored Urine
	Prostate / Sexual Dysfunction		Diabetes
	Menstrual Cycle Dysfunction		Cancer

What do you hope to get from chiropractic care? _____

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, Healthcare operation, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosers have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient **Date**