Confidential Patient Health History

Legal Name _____ Preferred Name_____
Social Security Number _____ Date of Birth_____ Male/Female
Address_____ City _____ State_____ Zip _____
Home Phone ( )_____ Cell Phone ( )_____ Email _____
May messages be left on your answering machine or voicemail? Y/N
Employer _____ Occupation_____ Work Phone ( )_____
Martial Status M S D W Preferred Language: _____
Family Medical Doctor _____ Date of Last Physical_____

Race (circle all that apply): White African American Hispanic American Indian
Chinese Other_____ I choose not to specify
Ethnicity: Hispanic/Latino Not Hispanic/Latino I choose not to specify
Security Verification Question-What city were you born in? _____

Spouse/Guardian Name _____
Spouse/ Guardian Birthday_____ Spouse/ Guardian SSN_____
Address if different than patient_____

Emergency Contact _____ Phone_____ Relationship_____
How did you hear about us? _____

What brings you into the office today? _____
How long have you had this condition?_____ Have you had it before? Y/N
Was this caused by: Auto Accident Work Accident Other _____

Surgery	Year	Injury	Year
_____		_____	
_____		_____	
_____		_____	
_____		_____	

List Allergies _____
List Family Health Problems _____
List Current Medications _____

Do you currently smoke or chew tobacco? Yes/No If yes, how long? _____
How much per day?_____ Are you interested in quitting? Yes/No
Are you a former smoker? Yes/No Do you drink Alcohol? Yes/No Amount _____

Do you have hypertension/high blood pressure? Yes/No Onset Date_____
Do you have Diabetes? Yes/No Onset Date_____ Type I / Type II
Was your blood lab-work test for hemoglobin A1c > 9.0%? Yes/No/Not Sure
Have you had an x-ray, CT Scan, or MRI of your low back in the past 28 days? Yes/No

Please indicate if you have had any of the following in the past year

General

___ Allergy
___ Seizures
___ Dizziness
___ Fatigue
___ Headache
___ Numbness in _____
___ Tremors
___ Unexplained Weight Loss

Muscle and Joint

___ Arthritis
___ Hernia
___ Low Back Pain
___ Neck Pain/Stiffness
___ Pain Between Shoulders
___ Sciatica
___ Swollen Joints

Skin

___ Bruise Easily
___ Varicose Veins

Respiratory

___ Chest Pain
___ Difficulty Breathing
___ Wheezing

Cardio-Vascular

___ High Blood Pressure
___ Poor Circulation
___ Rapid/Slow Heartbeat

Eyes, Ears, Nose. Throat

___ Asthma
___ Deafness
___ Chronic Earaches
___ Ear Noises
___ Eye Pain
___ Nosebleeds
___ Sinus Infections

Gastro-Intestinal

___ Colitis
___ Constipation
___ Diarrhea
___ Gallbladder Trouble
___ Hemorrhoids
___ Nausea/Vomitting
___ Poor Appetite

Genito-Urinary

___ Bed-wetting
___ Discolored Urine
___ Frequent Urination
___ Lack of Bladder Control
___ Kidney Infection/Stones
___ Prostate Trouble

For Women Only

___ Severe Cramps/Backache
___ Hot Flashes
___ Irregular Cycle
___ Menopausal Symptoms
___Currently Pregnant

AUTHORIZATION AND RELEASE: I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to healthcare providers and payors for communication and to secure benefits. I understand that I am responsible of all costs of chiropractic care regardless of insurance coverage. I certify that the information I have provided on this form is true to the best of my knowledge.

Signature_____ Date _____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) which are recommended by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the Dr. Hoops.

I have had the opportunity to discuss with the doctor or chiropractic and/or office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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, muscle strain, disc injuries, sprains, and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature _____ Date_____

Privacy Notice Written Acknowledgment:

I have been offered and/or received a copy of Hoops Chiropractic, PC Notice of Privacy Practice and any questions regarding it have been answered.

Patient/ Guardian Signature _____ Date_____

Hoops Chiropractic, PC Financial Policy

Patients with Insurance
We will happily telephone your insurance company to verify your coverage benefits. The benefits quoted to us by your insurance company are not a guarantee of payment. We will file your claim and await payment for 60 days. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. All deductibles and co-pays are due at the time of service.

Patients without Insurance
Payment for services is due at the time services are rendered unless payment arrangements are approved in advance. We are happy to accept cash, check, all major credit cards, and debit cards.

Worker's Compensation
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of the their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees are due immediately.

Personal Injury and Automobile Accidents
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 3 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Medicare
We accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for chiropractic care is ONLY manual adjustments of the spine. Medicare pay 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services.

I have read and understand the payment policy or Hoops Chiropractic, PC. I understand that my insurance is an arrangement between my insurance company and me, NOT between Hoops Chiropractic, PC and my insurance company. I request Hoops Chiropractic, PC or its billing service to prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond in 60 days, or if I suspend or terminate care, that fees will be due and payable immediately.

Patient/Guardian Signature_____ Date_____

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 CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization:
- Treatment, Payment, Health care operations
- When release is required by law, including in judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue and other donation organizations, upon or proximate to your death if you have no indication on hand about your donation preferences.

Special cases
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
- To the sponsor of your health plan.

Other
- All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:
Restrictions: To request restricted access to all or part of your PHI. We are not required to grant your request.
Confidential communications: To received correspondences of confidential information by alternate means or location.
Access: To inspect or receive copies of your protected health information.
Amendments: To request changes be made to your PHI. We are not required to grant your request.
Accounting: To receive an accounting of the disclosure by us of your PHI in the six years prior to your request.
This notice: To get updates or reissue of this notice, at your request.
Complaints: To complain to us or the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated. The law forbids us from taking retaliatory action against you if you complain.
Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Hoops Chiropractic,PC is in compliance with the HIPAA Omnibus Rule. Hoops Chiropractic,PC will not disclose Private Health Information without authorized permission from a patient. Private Health Information would be used/disclosed with authorized permission for marketing purposes. If you do not give express permission, we will not use your information for marketing purposes. If a patient requests a digital copy of certain electronic Private Health Information or directs Dr. Hoops in writing to transmit a copy to another person, Dr. Hoops will produce the information in the format requested (if readily producible) within 30 days or negotiate an alternative format. Further, if a patient requests that a copy of his or her Private Health Information be sent via unencrypted email, Dr. Hoops will be permitted to do so, providing that the patient is aware of the risks and prefers the unencrypted email.

As a patient, you have a right to restrict any disclosures made to health plans for payment or health care operations purposes if the Private Health Information pertains to an item or service for which you paid COMPLETELY out of pocket.

Hoops Chiropractic,PC has completed a Risk Assessment regarding Private Health Information and has found no breaches in security. If in the event a breach occurs Hoops Chiropractic, PC will inform affected patients and perform another Risk Assessment to address any changes that need to be made. Hoops Chiropractic,PC takes the protection of Private Health Information very seriously and maintains strict compliance with any and all HIPAA requirements.

By signing you are acknowledging that you have read the Update Privacy Policy.

_____ _____

Signature: Patient or Legal Representative Date Signed

 09202013