HUGHES FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT INTAKE AND ELECTRONIC HEALTH RECORDS FORM

Please fill out **ALL PORTIONS** of this form. If you need help, please ask the receptionist. If your injury is the result of an **AUTO ACCIDENT** or **ON-THE-JOB INJURY**, please inform the receptionist **NOW**.

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

Name: _____
First Middle Maiden Last

Address: _____City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Employer: _____ Occupation: _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widow/er

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred Language: _____ Preferred method of communication for patient reminders (Circle one): Email/ Phone/ Mail

Smoking Status (Circle one): Everyday smoker / Occasional smoker / Former smoker / Never smoked

Are you currently taking any medications? **Please include dosage and frequency** (Please include regularly used over the counter medications)

_____

_____

_____

Do you have any medication allergies? **Please include name of medication, onset, and reaction**.

_____

Give a brief description of the problems you are experiencing: _____

_____

When did you first notice symptoms or Injury occur? Date: _____ Where? _____

Was it caused by: ☐ Strain ☐ Injury ☐ Fall ☐Auto Accident ☐ Work-Related ☐ None of these

Describe circumstances: _____

Has this caused you to miss work? ☐Yes ☐No Is your condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily ☐ Other

Have you had any X-Rays of the spine in the last two years? _____ If so, where were they taken? _____

Are you **pregnant**? ☐Yes ☐No ☐Possibly ☐N/A If yes, due date: _____ OBGYN: _____

Have you had Breast Implants? ☐Yes ☐No ☐N/A (If yes, inform the doctor before treatment.)

Please turn page over

List all major surgeries: _____

_____

CASE HISTORY **Have you ever had any of the following?** (Please circle)

Appendicitis	Black Lung	Arthritis	Pneumonia	Whooping Cough
Mumps	Lumbago	Asthma	Measles	High Blood Pressure
Influenza	Tuberculosis	Cancer	Fainting	Low Blood Pressure
Dizziness	Goiter	Polio	Diabetes	Chicken Pox
Headaches	Neuralgia	Epilepsy	Alcoholism	HIV/AIDS
Numbness	Anemia	Pleurisy	Eczema	Venereal Disease
Backache	Nervousness	Weight Loss	Heart Disease	Poor Digestion
Pain over heart	Poor circulation	Mental Disorder	Rheumatic Fever	Pacemaker

Other (specify) _____

FAMILY HISTORY	**Diabetes**	**Heart Problems**	**Kidney**	**Liver**	**Cancer**	**Back Problems**
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Brother, No. of ____	☐	☐	☐	☐	☐	☐
Sister, No. of ____	☐	☐	☐	☐	☐	☐

☐ Adopted

Other important family history factors: _____

I authorize this office to release information concerning my condition to any third party payer. I also authorize assignment of benefits payable to Total Health Associates.

I give permission to release any medical records pertaining to my condition, appointments, financial, and insurance records to the following:

Name: _____ Address: _____

Telephone: _____ Relationship to patient: _____

Name: _____ Address: _____

Telephone: _____ Relationship to patient: _____

Name: _____ Address: _____

Telephone: _____ Relationship to patient: _____

I understand that I can cancel this release at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the provider receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER receives my written notice.

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often left blank as a result of the nature and frequency of chiropractic care.)

Date: _____ Patient's Signature: _____

Parent's Authorization to treat if patient is a minor. Parent's Signature: _____

Hughes Family Chiropractic
Financial Policy and Insurance Information

Payments for services are due at the time services are rendered. We accept cash, checks, and credit card payments.

In some instances we may accept assignment of insurance benefits. Check with the front desk person to see if your insurance plan covers chiropractic care before you receive treatment.

In order to ensure proper chiropractic care, a preliminary exam and periodic exams are required. There is a charge for these exams. Your doctor may recommend therapies as well. There is a charge for therapy as well. Please notify the doctor or assistant if, for any reason, you do not want to receive a therapy.

We must emphasize that our relationship is with you, the patient, not your insurance company. All charges are your responsibility if not collectible from your insurance carrier.

If you have any questions, please do not hesitate to ask us.

If you are covered by any medical insurance, complete this section:
Your insurance company name:________________________ Name of insured:___________________________________
Identification #_____________________________________ Group #____

If your injury is the result of an auto accident, complete this section:
Auto insurance company name:___________________________ Phone #_______________________________________
Policy #____ Claim #_______________________________________

If your injury was an on-the-job injury, complete this section:
Name of employer:____________________________________ Phone #____
Supervisor:____ Is there an attorney involved?________________________

♦♦

I, ___________________________ have read and understand this Financial Policy and agree to abide by this policy.

☐ I do not have any medical coverage and will pay in full.

☐ I want Hughes Family Chiropractic to file claims to my insurance company. I understand that I am responsible for any portion of the charges that my insurance does not cover.

☐ I have insurance, but do not want claims filed. I will pay in full at each visit and understand that if I decide to file at a later date, my insurance company may consider it not done in a timely manner, and may not cover the charges.

Patient's Signature:____ Date:________________________

Revised 04/04/2016

HUGHES FAMILY CHIROPRACTIC

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We have established the appropriate safeguards to protect the privacy of your health information. Total Health Associates LLC (doing business as Hughes Family Chiropractic) will not disclose any personal information about you except as required or permitted by law. Please review it carefully.

1. ***We will disclose personal information if required by state, federal, or local law. For example, if required by a court order.***
2. ***We may use or disclose your personal information for your treatment. For example, we may disclose information as required to another physician involved in your care.***
3. ***We may use and disclose your personal health information to achieve payment. For example, to achieve payment by an insurance carrier.***
4. ***We may use your personal information in order to support the business activities of Hughes Chiropractic. For example, we may use personal information in order to mail out postcards, newsletters.***
5. ***If you are a member of the armed forces, we may be required to provide information to military authorities. We can use or share information for workers' compensation claims, law enforcement purposes.***
6. ***We may disclose personal health information as required if public health risk is evident. For example, suspected abuse or neglect.***
7. ***If you are an inmate or under custody of the law enforcement official, we may be required to release personal health information to these authorities.***

<u>Our Responsibilities</u>:

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information. We must follow the duties and privacy practices described in this notice. We will not share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Please turn over

Your Rights:

1. ***You can ask to see or get a copy of your medical record information we have about you. Ask us how to do this. We will provide a copy of your health information, usually within 30 days of your request. We may charge a reasonable cost-base fee.***
2. ***You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.***
3. ***If you pay for service out of pocket in full, you can ask us not to share that information with your health insurer.***
4. ***You can ask us to contact you in a specific way (for example, home or office phone). We will say "yes" to all reasonable requests.***
5. ***You can choose someone to act for you (example, if you have given someone power of attorney or someone is your legal guardian.) We will make sure the person has this authority before we take any action.***
6. ***You can complain if you feel we have violated your rights by contacting our Privacy Office Manager (Connie Jones) at Hughes Family Chiropractic 1918 North Belt Highway St. Joseph Mo 64506 or by phone (816) 279-3319. You can also call US Health and Human Services at 1-877-696-6775 or by visiting www.gov/ocr/privacy/hipaa/complaint. We will not retaliate against you for filing a complaint.***
7. ***By signing this notice I acknowledge that I have received a copy of Total Health Associates (doing business as Hughes Family Chiropractic) Patient Privacy Policy Notice.***
8. ***Some of your care may be done in an open area in front of other patients. A private room is available upon your request.***

We reserve the right to change the terms of this notice.

The most current notice will be posted at the front desk in our office.

☐ ***I do not wish to receive a copy of this policy today but I know I may ask for a copy at any given time.***

Print Name: _____

Sign: _____

Date: _____

Hughes Family Chiropractic
Dr. Charles Hughes and Dr. Richard Hughes
1918 N. Belt Highway
St. Joseph, MO 64506 (816) 279-3319

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including acupuncture and various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic indicated above and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedure.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

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 the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient (Printed): _____

Signature of Patient: _____

Name of Guardian/Parental and Relationship to Patient (Printed):_____

Guardian/Parental Signature: _____

Date: _____