COLUMBIA
CHIROPRACTIC CENTER Keeping Columbia Moving.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

HIPPA CONSENT

Patient Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Legal Name_____ How would you like to be addressed?_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ SSN#:____-____-_____ Date of Birth:____/____/_____ Age:_____
☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced
Preferred contact methods: ☐Cell phone ☐Home phone ☐Work Phone ☐Email ☐Text(cell carrier)_____
If you have children, how many?_____ Names and Ages:_____
Employer _____ Occupation _____
How did you hear about our office?
☐Columbia Chiropractic Center Website ☐Search Engine:_____ ☐Community Event:_____
☐Health Talk:_____ ☐Law Firm:_____ ☐Dr Referral:_____
Patient Referral - who can we thank for sharing the benefits of care with you?_____

Have you ever had Chiropractic Care? ☐Yes ☐No
If yes, please tell us the doctor's name and when care occurred:_____
Were you pleased with your care? ☐Yes ☐No
Are you receiving care from other health care professionals? ☐Yes ☐No
If yes, please name them and their specialty:_____
Who is your family's primary care physician:_____
Columbia Chiropractic Center believes that health care is a team effort. May we have your permission to update your medical doctor regarding your care at this office? ☐Yes ☐No

Please list any medications, herbs, supplements, homeopathic or other remedies you are currently taking:
_____
_____
Please list any surgeries you've had and the date:_____
_____
_____

INSURANCE

Have you provided our staff with a copy of your insurance card? ☐Yes ☐No
If no, please present your card upon completing this paperwork
How are you insured? (check all that apply)
☐Individual policy ☐Insured through employer ☐Medicaid (Title 19)
☐Medical Savings Account & Flex Plans ☐Automotive/Work Comp ☐Other: _____
If policy holder is someone other than the patient, please provide:
Policy Holder Name:_____ DOB:_____/_____/_____
Relationship:_____ SSN:_____-_____-_____
Address (if different from above): _____
Street City State Zip

NOTICE OF AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

FAMILY & SOCIAL

How often do you drink alcoholic beverages?_____ Do you smoke? ☐Yes ☐No How much?_____

Do you exercise? ☐Yes ☐No How often?_____ Type?_____

Women: Are you currently pregnant? ☐Yes ☐No Date of last menstrual cycle?_____

Check those involving family and include identification: **M** = mother, **F** = father, **S** = sibling, **G** = grandparent

Cancer, type_____	**Depression**	**Diabetes**	**Back Problems**
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Heart Disease	**Liver Disease High**	**Blood Pressure**	**High Cholesterol**
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Lung Problems	**Scoliosis**	**Neck Problems**	**Osteoporosis**
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Seizures	**Osteoarthritis**	**Rheumatoid Arthritis**	
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	

CHIROPRACTIC

Do you know what a subluxation is? ☐Yes ☐No

Do any of your friends or relatives see a chiropractor? ☐Yes ☐No

If yes, do they use chiropractic for: ☐Health maintenance/optimization ☐ Health problems ☐Both

Are you seeking chiropractic for: ☐Health maintenance/optimization ☐ Health problems ☐Both

Are you aware of the massive benefits of chiropractic care for children? ☐ Yes ☐ No

What would you like to gain from chiropractic care?_____

_____

_____

AUTHORIZATION

Consent for Treatment

Assignment & Release *- By signing below, I authorize Columbia Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Columbia Chiropractic Center and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my informed consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Name of Patient:_____Date:_____

Signature of Patient/Legal Guardian:_____

HEALTH HISTORY

What health condition brings you to our office:_____

Indicate the current intensity of your complaint:

Mild Severe

1	2	3	4	5	6	7	8	9	10

Indicate the percentage of daytime it is present:

None All Day

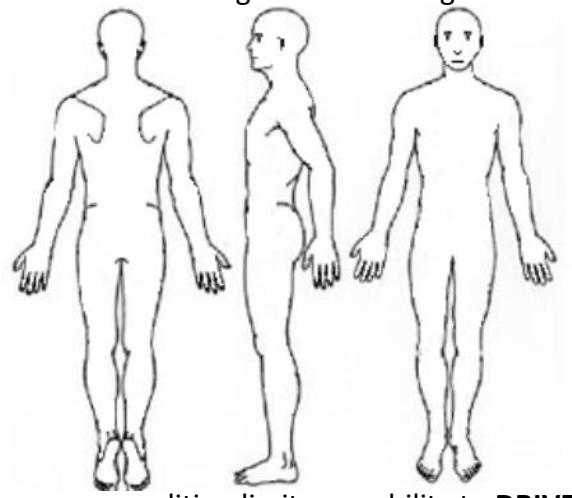
1	2	3	4	5	6	7	8	9	10

How long have you been experiencing your main complaint?_____

Has the intensity ever been at a level of 9 or 10? ☐Yes ☐No

Using the letters below, please show <u>where</u> you are experiencing all of your current complaints:

A=Ache **B**=Burning **ST**=Stabbing **C**=Cramping **N**=Numbness **P**=Pins and Needles **T**= Throbbing



What makes it feel better:_____

What makes it feel worse:_____

Does this affect your work or other activities:

☐Decision making ☐ Unable to work

☐Decreased productivity ☐ Poor attitude

☐Exhausted at end of day ☐Other: _____

☐Unable to work Poor attitude

Does this affect your life:

☐Lose patience with spouse or children

☐Restricted household duties

☐Hinders ability to exercise/play sports

☐Hinders ability to participate in hobbies/recreation

DAILY ACTIVITIES

Does your condition limit your ability to **DRIVE**?

☐Unable to drive due to pain ☐Able to drive 60 minutes ☐30 minutes ☐10 minutes ☐No limitation Does your condition limit your ability to **CARRY** objects?

☐Unable to carry any weight ☐Can carry heavy objects ☐Moderate objects ☐Light objects ☐No limitation Does your condition limit your ability to **SLEEP**?

☐Unable to sleep ☐Loss of 3-5 hours ☐Loss of 2-3 hours ☐Loss of 1-2 hours ☐No limitation Does your condition limit your ability to **STAND**?

☐Unable to stand ☐Able for <10 minutes ☐15 minutes ☐30 minutes ☐60 minutes ☐No limitation Does your condition limit your ability to **SIT?**

☐Unable to sit ☐Able for 1 hour ☐Able for 2 hours ☐Able for 4 hours ☐Able for 8 hours ☐No limitation Does your condition limit your ability to go from **SITTING TO STANDING**?

☐Unable without help ☐Able from high chair ☐Recliner ☐Medium chair ☐No limitation

Does your condition limit your ability to **WALK**?

☐Unable to walk ☐No more than 10 feet ☐100 feet ☐½ mile ☐1 mile ☐No limitation Does your condition limit your ability to perform **HOUSEWORK**?

☐Unable to do housework ☐Able to do <10 minutes ☐15 min ☐30 min ☐60 min ☐No limitation

Does your condition limit your ability to **BEND**?

☐Unable to bend ☐Can bend 1⁄4 of the way ☐Can bend halfway ☐Can bend ¾ of the way ☐No limitation

In the event that we can help, what is your level of commitment to correcting your problem (s)?

LOW **MEDIUM** **HIGH**

1	2	3	4	5	6	7	8	9	10

I acknowledge that the above information is true and accurate to the best of my knowledge

Patient Signature:_____ Patient name:_____ Date:_____

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Pregnancy Waiver

I hereby acknowledge that a doctor from Columbia Chiropractic Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated of my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed name of Patient

_____

Date

_____

Signature of Patient/ Authorized Representative of Patient

WITNESSES

_____

Printed name

_____

Signature