POOLE CHIROPRACTIC

CASE HISTORY

(Please print)
FULL NAME:_____ TODAY'S DATE:_____

ADDRESS:_____APT#____CITY_____STATE____ZIP_____

HOME PHONE:_____CELL PHONE:_____ Email:

BIRTHDATE:___/___/_____ AGE:_____SEX: __M__F STATUS: __M__S__W__D # CHILDREN_____

EMPLOYER'S INFORMATION
OCCUPATION:_____EMPLOYER_____YRS EMPLOYED:_____
ADDRESS:_____CITY_____STATE___ZIP_____ PHONE#_____
SPOUSE'S NAME:_____OCCUPATION_____EMPLOYER_____
PERSON RESPONSIBLE FOR ACCOUNT_____REFERRED BY_____

WHAT IS YOUR MAJOR COMPLAINT? HOW DID IT BEGIN?

_____
_____
_____

Is this? Work related ☐ Auto related ☐ N/A ☐
1. How long have you had this condition?_____
2. Have you had this or similar conditions in the past?_____
3. What activities aggravate your condition?_____
4. Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
5. Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other_____
6. How long has it been since you really felt good?_____
7. List surgical operations and dates performed:

_____
_____
_____

8. Are you taking any medications?_____ If so, what kind?_____

9. Other doctors seen for this condition: ___MD ____DC ____DO____DDS
Doctor's Name:_____ Practice Name:_____ Diagnosis:_____Date:___

10. Rate your pain on the scale below (how you feel today):
No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Unbearable Pain

11. How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
12. Have you had spinal x-rays, MRI, or CT Scan? ☐ Yes ☐ No Date(s) taken and what area?_____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature:_____ Date:_____

POOLE CHIROPRACTIC

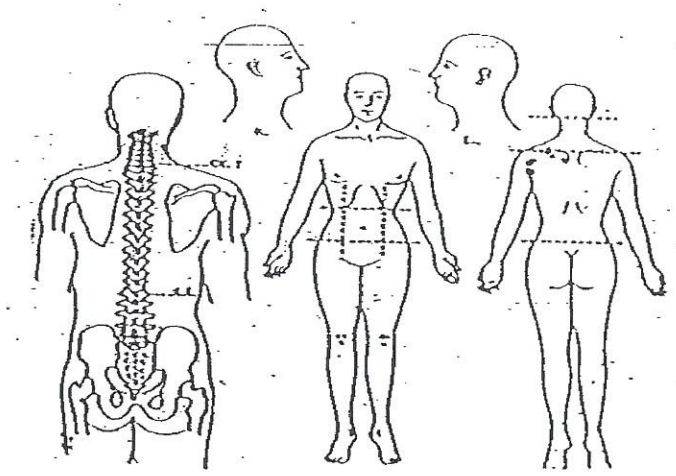
INITIAL HEALTH STATUS

Patient Name:_____ Date:_____

In the diagrams below, mark the areas of the body, using the symbols, where you have experienced any of the following symptoms **this past week:**

Symbols

ACHING	XXXX
BURNING	^^^^
STABBING	////
PINS & NEEDLES	0000
NUMBNESS	----------



Please check all of the following that apply to you: ☐ None Apply

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date)_____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain)_____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain)_____

_____

- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, #weeks_____, #births____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries_____

_____

- ☐ Medications_____

_____

- ☐ History of Alcohol Use ☐ History of Tobacco Use

Family History: ☐Cancer ☐Diabetes ☐High Blood Pressure ☐Heart Problems/Stroke ☐Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

POOLE
CHIROPRACTIC

Patient's Name_____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Your HMO insurance company requires authorization after the first six or eight visits, depending on which insurance company you have. Our office does the best we can do to make sure that the visits necessary for your recovery are authorized; however, there are times when the insurance company does not authorize the number of visits we think are necessary. Also, your insurance company does not cover any therapy, such as ultra sound or stim therapy. There are some x-rays that the insurance does not cover and they do not include any supplements.

Please choose one option below and circle it:

Option 1. **Yes**, I want to receive these items and/or treatments and I agree to be personally and fully responsible for payment.

Option 2. **No**, I have decided not to receive these items or services if they are not authorized.

Signature:_____ Date:_____

POOLE CHIROPRACTIC

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the differences between the health care specialists of chiropractors, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Sine there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understood the foregoing.

DATE

SIGNATURE

POOLE CHIROPRACTIC

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____(patient name), hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
4. I understand that I have the right to request how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to request restriction, then the restriction is binding on the Practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
6. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign the Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____
Name of Individual (Printed)

_____
Signature of Individual

_____
Signature of Legal Rep.
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

_____
Relationship

Date Signed_____

Witness_____

POOLE CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

Effective 4/14/03

IMPORTANT: 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.

Poole Chiropractic is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how Poole Chiropractic is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so. We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff is committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE: HIPAA Privacy Officer Liaison, Carol Moltz, at (714) 282-6141.

Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization. Poole Chiropractic is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For Poole Chiropractic's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew.
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;

- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.**

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI. This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed in this Notice.

The right to amend your PHI. The right to request amending your PHI. You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed in this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. Poole Chiropractic is not required to agree to any restrictions you request, but any restrictions agreed to by Poole Chiropractic are binding on Poole Chiropractic.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. We have a copy of this Notice on our website at **www.PooleChiropractic.com**. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: Poole Chiropractic reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our website. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed in this Notice.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

HIPAA Privacy Officer Liaison
Carol Moltz
1289 E. Lincoln Ave., Orange, CA 92865
Tel: (714) 282-6141, Fax (714) 282-0513

Or

U.S. Department of Health & Human Services
Office of the Secretary
200 Independence Avenue, S. W.
Washington, D.C. 20201
Tel: (202) 619-0257, Toll Free: (877) 696-6775
http://www.hhs.gov/contacts