CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date _____

Address _____ City_____

State_____ Zip_____ Birth Date_____ Age____ Height____ ft____ in Weight_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail Address_____ Occupation_____ Employer _____

Marital Status □ Single □ Married □ Divorced □ Widowed Spouse's Name _____

Who should we contact, in the event of an emergency? _____

Relationship_____ Home Phone_____ Work_____ Cell_____

If you are not responsible for your bill, who is? _____ Relationship_____

Address (if different than above) _____

City_____ State_____ Zip_____ Phone_____

Who can we thank for your referral? _____

Previous chiropractic care: □ yes □ no Dr. _____ Last treatment_____

INSURANCE? □ Yes □ No - Personal Pay

Insurance Carrier_____ Health Plan_____

Subscriber Name_____ ID#_____ Group #_____

Secondary Insurance _____

CURRENT COMPLAINT / HEALTH HISTORY

Is this? □ Auto related – date of accident_____ □ Work related – date of accident_____ □ Other

List your conditions, dates of onset and how they began _____

_____

_____

Circle how you feel today (No pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

What percent of the day are your symptoms present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Are you getting? □ Better □ Worse □ Same

What makes it better? _____ What makes it worse? _____

Does it affect your □ Sleep □ Daily Routine □ Work? Describe _____

_____

List other Doctors seen for this condition _____

Any recent x-rays or scans? □ yes □ no Date_____ Areas _____

Any similar conditions in the past? □ yes □ no If yes, describe _____

_____

Are you taking any medications for your conditions? □ yes □ no How effective? _____

Have you lost/ gained weight recently? □ yes □ no Have you had any loss of bladder control? □ yes □ no

For Women: Are you pregnant? □ yes □ no Do you use birth control pills? □ yes □ no

Any history of the following?

□ Heart Attack	□ Low Blood Pressure	□ Hypoglycemia	□ Artificial Joints
□ Heart Surgery	□ Fainting / Dizziness	□ Asthma	□ HIV / Aids
□ Pacemaker	□ Seizures	□ Hepatitis	□ Headaches
□ Stroke	□ Cancer	□ Arthritis	□ Neck Injury
□ High Blood Pressure	□ Diabetes	□ Psychiatric Problems	□ Back Injury

Please list all surgeries and dates _____

_____

Please list major accidents and dates _____

_____

Do you smoke? □ yes □ no Drink Alcohol? □ yes □ no Use Caffeine? □ yes □ no
Do you exercise? □ yes □ no □ 1-2 days a week □ 3-4 days a week □ 5-6 days a week

What supplements do you take? _____

HEALTH CARE GOALS

□ Short term care – I want symptom relief only.
□ Reconstructive care - I want to know what is wrong and what I can do to correct it.
□ Wellness care – I want to be as healthy as possible and want to address lifestyle issues that impact my health including structure (spinal health), nutrition (diet) and exercise.

I HEREBY GIVE PERMISSION to the doctor to perform such procedures as necessary in the diagnosis and treatment of my condition, and to release information to my insurance company if necessary to facilitate the reporting and billing process.

I certify to the best of my knowledge that the above information is true and accurate. I understand and agree that I am personally responsible for all services rendered on my behalf including amounts not covered by insurance. I also understand that payment of these services or co-payments are due at the time of service. In the event I have a past due account (over 30 days), I agree to pay a finance charge of 1.5% per month or service charge of $5.00 per month whichever is greater on the outstanding balance.

Signature: _____ ***Date:*** _____
Patient/Guardian (I have read and agree to the above statements.)

Birdsley Health & Wellness Center

1360 South Main Street, Salt Lake City, Utah 84115, 801-467-7141

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 IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature_____ Print Name_____ Date_____

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