PRIVETTE FAMILY CHIROPRACTIC
Think again, think chiropractic!

CONFIDENTIAL HEALTH INFORMATION

All information you provide is confidential.
We comply with federal privacy standards.
Please allow our staff to photocopy your insurance card.

Privette Family Chiropractic
Dr. Harold Privette
101 Medical Sciences Drive
Union, SC 29379
P: 864-429-2912
F: 864-670-5004

Please print clearly.

_____
Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
_____ O No O Yes If so, when? _____ Whom? _____
Whom may we thank for referring you?

_____ _____ _____ _____
Your Last Name **Your Social Security Number** **Birth Date (MM/DD/YYYY)** **Age**

_____ _____
Your First Name **Your Middle Name (or initial)**

Gender
O Male O Female

_____ _____
Address **Race**

_____ _____ _____
City **State** **Zip Code**

Marital Status O Married O Single
O Divorced O Widowed O Separated

_____ _____ _____
Home Phone **Cell Phone** **Spouse's Name**

_____ _____
Email Address **Child's Name and Age**

_____ _____ _____
Emergency Contact **Emergency Contact's Phone** **Child's Name and Age**

_____ _____
Your Occupation **Child's Name and Age**

_____ _____
Your Employer **Work Phone**

_____
Primary Care Provider's Name

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email

_____ _____
Insurance Carrier **Policy Number**

Who carries this policy? O Self O Spouse O Parent (If not Self, please complete the information below.)

_____ _____ _____
Insured's Last Name **Insured's First Name** **Insured's Middle Name/Initial**

_____ _____ _____
Insured's Birth Date (MM/DD/YYYY) **Insured's Employer** **Insured's Employer's Phone Number**

_____
Insured's Employer's Address **City** **State** **Zip**

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. These symptoms are the result of (darken circle): O An accident or injury O Work O Auto Accident
0 A worsening long-term problem O Other: _____

3. Onset (When did you first notice your current symptoms?)

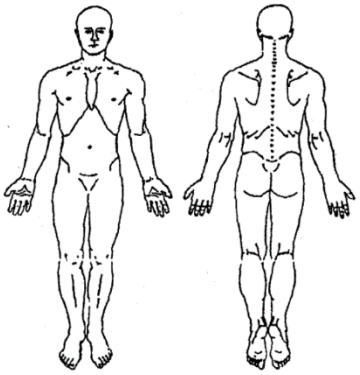
_____

4. Intensity (How extreme are your current symptoms?)
0 O-O-O-O-O-O-O-O-O-O **10**
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
O Constant O Comes and goes
How often? _____

6. Quality of symptoms
(What does it feel like?)
O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramps
O Nagging
O Sharp
O Burning
O Shooting
O Throbbing
O Stabbing
O Other: _____

7. Location (Where does it hurt?)
Circle the areas on the illustration.



8. Radiation (Does it affect other areas?)
_____

9a. What makes the symptoms better?
_____

9b. What makes the symptoms worse?
_____

10. Prior Interventions (What have you tried to relieve the symptoms?)
O Prescription medication O Surgery O Ice
O Over-the-counter drugs O Acupuncture
O Heat O Massage O Physical therapy
O Homeopathic remedies O Chiropractic
O Other: _____

11. Please list any therapies you are currently undergoing. _____

12. What else should we know about your current condition? _____

13. How does your current condition interfere with your:
Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

14. Please list any surgical interventions/operations and the year completed. _____

_____

_____

15. What is the major stressor in your life? _____

16. How much sleep do you average per night? _____ hours

17. What is your preferred sleeping position? _____

18. What is the type and approximate age of your mattress? _____ **Pillow?** _____

19. Social History: Alcohol use O Daily O Weekly How much? _____
Tobacco use O Daily O Weekly How much? _____

20. Typical eating habits: O Skip breakfast O 2 meals/day O 3 meals/day O Snacking between meals

21. What would be the most significant thing you could do to improve your health? _____

_____

22. Any additional health goals? _____

Consultation Notes

Patient Name _____ Date of Birth:_____

PATIENT CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Harold Privette and/or other licensed doctors of chiropractic who now or in the future work at Privette Family Chiropractic.

I have had an opportunity to discuss with the Dr. Privette and/or with other office or clinic 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, 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). This consent applies to all my present and future treatments at this clinic.

Payment Policy Agreement abbreviated: I understand and agree that my health/accident insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that I am personally responsible for payment of all services rendered to me, and minor if applicable. I also understand that if I suspend or terminate care, any fees for services rendered will be due immediately.

24 Hour Cancellation policy: I understand that I must provide 24 hour notice for appointment cancellation to avoid being charged a fee for that appointment.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Privacy & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have reviewed your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information at www.spineadjuster.com. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Privette Family Chiropractic to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Privette Family Chiropractic's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to singing this consent. Privette Family Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Privette Family Chiropractic 101 Medical Sciences Drive Union, SC 29379

With this consent form, Privette Family Chiropractic may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Privette Family Chiropractic may mail to my home or other alternative location any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential. With this consent form, Privette Family Chiropractic may email, to my home or other alternative location, any items that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that Privette Family Chiropractic restrict how it uses or discloses my protected health information (PHI) to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Privette Family Chiropractic's use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Privette Family Chiropractic may decline to provide treatment for me.

MEDICARE PATIENTS

The only chiropractic service covered by Medicare is manual manipulation of the spine to correct subluxation. I understand that Privette Family Chiropractic will file my insurance as a courtesy and any other services agreed to other than manual manipulation will be charged directly to me at the time the service is provided. I may request a copy of the Medicare ABN from the receptionist at any time.

I have read, or have had read to me, the above information. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Privette Family Chiropractic.

_____ _____

Signature **Date**

_____

Printed Name

_____ _____

Signature of Guardian if Minor Child **Relationship to Minor**