WELCOME

PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

City ______

State ______ Zip ______

E-mail ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______

Patient Employer/School ______

Employer/School Address ______

______

Employer/School Phone (_____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr.______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

PHONE NUMBERS

Home Phone (______) ______

Cell Phone (______) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______

Relationship ______

Home Phone (______) ______

Work Phone (______) ______

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date ______

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

______

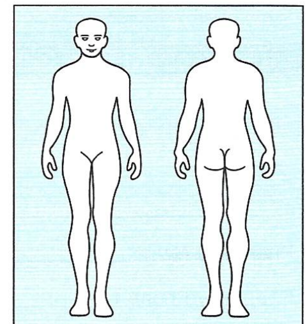
PATIENT CONDITION

Reason for Visit ______

When did your symptoms appear? ______

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______

Is it constant or does it come and go? ______

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ______

Name and address of other doctor(s) who have treated you for your condition ______

Date of Last: Physical Exam ______ Spinal X-Ray ______ Blood Test ______

Spinal Exam ______ Chest X-Ray ______ Urine Test ______

Dental X-Ray ______ MRI, CT-Scan, Bone Scan ______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ______		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	______		
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Smoking Packs/Day ______

☐ Alcohol Drinks/Week ______

☐ Coffee/Caffeine Drinks Cups/Day ______

☐ High Stress Level Reason ______

Are you pregnant? ☐ Yes ☐ No Due Date ______

Injuries/Surgeries you have had	Description	Date
Falls	______	______
Head Injuries	______	______
Broken Bones	______	______
Dislocations	______	______
Surgeries	______	______

MEDICATIONS

______

______

______

Pharmacy Name ______

Pharmacy Phone (____) ______

ALLERGIES

______

______

______

______

______

VITAMINS/HERBS/MINERALS

______

______

______

______

______

CHIROPRACTIC NEUROLOGY ASSOCIATES
2401 E. 42nd Street, Suite 204
Anchorage, Alaska 99508

CHIROPRACTIC TREATMENT/DIAGNOSTIC STUDIES CONSENT FORM

By my signature below, I ________________________ verify and represent to Chiropractic Neurology Associates

1. That I have consented to the performance of CHIROPRACTIC TREATMENT/DIAGNOSTIC STUDIES as they have explained the proposed treatment to me; and
2. That prior to giving my consent to this proposed treatment, the Chiropractic Physician has discussed with me, and offered me an opportunity to ask questions I had regarding each of the following matters:
   A. The risks and complications involved in the proposed treatment;
   B. The risks and consequences resulting from not undergoing the proposed treatment;
   C. The probability of a successful outcome from the application of the proposed treatment;
   D. The expected benefits resulting from the proposed treatment; and
   E. The alternative methods of treatment available to me and the risks and benefits associated with each alternative, and
3. That prior to giving my consent to this procedure, the Chiropractic Physician answered all questions, if any, I had concerning any matters listed above and provided me with all information that I desired regarding the proposed treatment; and
4. That the Chiropractic Physician also explained to me and I understand that while I am under treatment, risks and complications may arise during the course of the proposed treatment which may not have been foreseen at the time I gave my consent for the proposed treatment. Therefore, I further verify that I have agreed with the Chiropractic Physician that if any such unforeseen risks or complications should arise, I have also consented to further treatment by the Chiropractic Physician and/or by a physician as they deem in my best interest under the circumstances.

______________________ ______________________________
Date Signature of Patient/Representative

______________________ ______________________________
Date Signature of Doctor

Notice of Privacy Practices for PHI§164.520 - Acknowledgement Form

Patient Acknowledgement of Chiropractic Neurology Associate's HIPAA Notice of Privacy Practices

The Notice of Privacy Practices is an essential element of Chiropractic Neurology Associate's HIPAA compliance efforts. It's important for you a patient to understand your rights and for this clinic to understand our responsibilities. As HIPAA releases revisions, amendments or new policies regarding the Privacy and Security regulations management will update the Notice of Privacy Practices.

By signing below, I acknowledge that I have read Chiropractic Neurology Associate's Notice of Privacy Practices on the subject of compliance with the HIPAA Privacy of Patient's Health Information and understand my rights explained under this document.

Patient's Printed Name: ______________________________

Patient's Signature & Date: ______________________________

Privacy Official's Acknowledgement & Date: ______________________________

REFERENCE:

Notice of Privacy Practices 164.520 Policy, AK State comparative Health Privacy Law, Federal Register- www.hhs.gov

Cc: Patient file

RELEASE FORM

Allowable contact by Email /Text /Phone
Use of Testimonial (Written/Video/Photo)

Being a Health Care Provider, one of our top priorities is to protect you and your private health information (PHI). We go to great lengths to ensure that your PHI is well protected.

As well, at Chiropractic Neurology Associates we are passionate about clear communication and transparency. By supplying education, to help support your needs, as well as educate your family, friends and neighbors regarding healthy lifestyle changes and our services, everybody wins! This information causes us all to work harder at being healthy, helps us make better life decisions, and builds healthier communities.

As you know, we live in an ever increasingly technological age that exchanges information via cell phones, social media and internet-based activity. We have all made changes in how we connect and communicate. This advanced ability to communicate has created wonderful opportunities to create a global community, but also opens possibilities for misuse of these options. We want to communicate with you in a way that is convenient and comfortable for YOU! Please let us know you preferences below:

Authorization for Release of Information

We are requesting your permission for Chiropractic Neurology Associates to communicate with you in the following ways:

1) I authorize Chiropractic Neurology Associates to call/fax and/or leave voice or text messages, that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc. -at the following phone number/numbers ;

   ____________, _____________,_____________.
   ______ Initial here for your consent

2) I authorize Chiropractic Neurology Associates to utilize the following email addresses to send messages that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc.;

   Email addresses: ______________________, ____________________,_____________.
   ______ Initial here for your consent

TESTIMONIALS

3) **I choose to give a patient testimonial** for the purpose of, but not limited to, the publication or promotion of my thoughts, feelings, and experiences, as they relate to Chiropractic Neurology Associates , Dr. Brandvold, and /or staff.

   I understand my testimonial/review, made on behalf of Chiropractic Neurology Associates, may be used in connection with publicizing and promoting Chiropractic Neurology Associates. I authorize Chiropractic Neurology Associates to use my name, brief biographical information, and the Testimonial/Review, as well as any photographs of me. The effective date is the first day of any services provided by Chiropractic Neurology Associates, Dr. Brandvold, and /or staff.

   I hereby irrevocably authorize Chiropractic Neurology Associates to copy, exhibit, publish or distribute pictures, video and/or my written Testimonial/Review for purposes of publicizing Chiropractic Neurology Associates programs or for any other lawful purpose. These statements, photos or videos may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Chiropractic Neurology Associates for the use of the statement, testimonials/reviews, video or pictorial representations of me. In addition, I waive any right to inspect or approve the finished product, including written copy or edited video wherein my likeness or my testimonial appears. I hereby hold harmless and release Chiropractic Neurology Associates from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons, acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.

   _______ **Initial here for your consent**

I have read the information above and authorize the initialed sections.

Signature: ____

Printed Name: ____

Email: ____

Address: ____

City, State, Zip: ____

Cell phone: ______________________________ Date: ______________

CHIROPRACTIC NEUROLOGY ASSOCIATES

AUTHORIZATION FOR RELEASE OF INFORMATION
AND MEDICAL RECORD RELEASE

I,__________________________________born on the _________day of____________
Hereby authorize any doctor or employee of said clinic at 2401 East 42nd Ave Ste 204 Anchorage, Alaska 99508 to request, obtain and take receipt of any and all information relating to my medical care and treatment records. Further, I release all liability for disclosure to my doctor.

This authority includes, but is not limited to medical reports records, health records, X-rays diagnostic and hospital records.

The authority included, but is not limited to the inspection, copying and receipt of my medical records. I hereby request that all persons cooperate fully in providing my doctor with such information. A photocopy of the Authorization and Release shall be equally valid as the original.

DATED this __________________day of ___________________20______

______________________________ _________________________
Patient Guardian's Signature *Patient/Guardian SS#*

2401 E 42nd Ave #204
Anchorage, AK 99508
907 563 6761 main
907 562 3587 fax