Hardinsburg Chiropractic/ Dr Stefan Cesarz 112 Bank Street Hardinsburg, KY 40143

AUTO

Welcome. Dr. Stefan Cesarz and the staff at Hardinsburg Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will assist you in finding the appropriate health care provider.

Patient Information

Name:_____ Employer:_____

Nickname:_____ Occupation:_____

Address:_____ Marital status: M S W D

City:_____State:____Zip:_____ Spouse's Name:_____

Phone Number: (Home):_____ Name of Parent or Legal Guardian of Minor (if applicable)

(Work):_____ _____

(**Cell**):_____ Whom can we thank for referring you to our office?

Date Of Birth:_____Age:_____ _____

Social Security No.:_____ **Email address**:_____

Accident Information

Date of Accident: _____ Location of Accident: _____

Describe the accident (rear ended, head on, roll over, etc.):_____

Were you the Driver__ or Passenger__ Front seat__ Back seat__ Were you wearing your seat belt? Yes__ No__

Did the Air Bags go off? Yes__ No__ Where were you taken after the accident? Hospital/ ER__ Doctor's Office__ Home__

Was an accident report filed with the police? Yes__ No__

Name of Insurance Co.:_____ Claim #:_____

Health Information

What is your main complaint today? _____

When did your symptoms begin? : _____ Have you had this condition in the past? : ___YES___NO

How often do you symptoms occur? ___Occasional ___Intermittent ___Frequent ___Constant

What makes your complaints **worse**? ___Coughing ___ Sneezing ___ Straining at Stool ___Reaching ___Lifting ___Bending ___Sitting ___Standing ___Walking ___Laying down ___Other _____

What makes your complaints feel **better**? ___Nothing ___Rest ___Ice ___Heat ___Stretching ___Exercises ___Sitting ___Standing ___Laying down ___Other_____

Is your condition getting? ___Worse ___Better ___Staying the same

Have you been examined and/or treated by another Doctor for this condition? ___YES ___NO

If YES, please list the Doctor(s), last visit date, treatments and/or test results; _____

Have you received Chiropractic care in the past? ___YES___NO Name of Doctor and date of last visit? _____

Do you suffer with pain in any of the following areas? :___Jaw/ TMJ___Shoulders___Elbows___Wrist/ Hands___Knees___Ankles

Please list any **additional** complaints: _____

Have you had any surgeries and/ or been hospitalized in the past **five** years? ___YES ___NO Date(s) and reason: _____

Have you ever suffered a stroke? ___YES ___NO Have any of your relatives suffered a stroke? ___YES ___NO

Please mark what medications you are taking;___Muscle Relaxants ___Prescription pain pills ___Ibuprofen/ Tylenol ___Aspirin ___Blood pressure pills ___Birth control pills ___Antibiotics ___Cholesterol lowering pills

___Others: _____

Which of the following illnesses or diseases have you had or are currently experiencing?

___Arthritis	___Heart/ Valve trouble	___Spinal disc disease	___Weakness in legs/ feet
___Asthma	___Difficulty urinating	___Multiple Sclerosis	___Cold feet
___Sinus Infections	___Loss of Bowel control	___Mental/ Emotional difficulty	___Leg cramps
___Allergies	___Loss of Sexual Function	___Prostate trouble	___Constipation or Diarrhea
___Tuberculosis	___Ulcer	___Kidney disease	___Increased menstrual cramps
___Diabetes	___Cancer	___Headaches	___Difficulty sleeping
___Epilepsy	___Polio	___Cold hands	___Restless legs
___Thyroid trouble	___Rheumatic fever	___Weakness in grip	___Bone fractures
___High Blood Pressure	___Dislocated joints	___Numbness/ tingling arms/ hands	
___Low Blood Pressure		___Numbness / tingling legs/ feet	

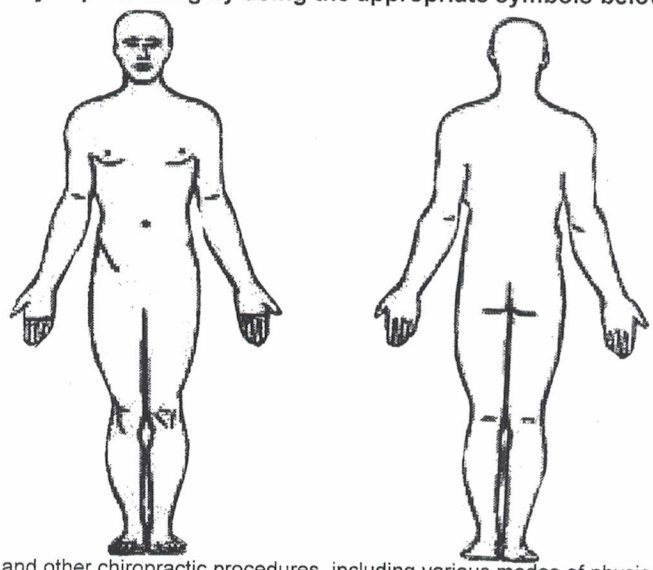
(revised 05-17)

Hardinsburg Chiropractic, PSC/ Stefan Cesarz, DC

Patient Name: _____

Please mark the area(s) of pain or unusual feeling you are currently experiencing by using the appropriate symbols below.

Numbness: =====
Tingling: ooooo
Burning: xxxxx
Aching: +++++
Stabbing: //////



Patient Informed Consent

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 the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above and/ or other licensed Doctors Of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor of Chiropractic named above, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to examination and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement in my condition. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

_____ Print Patient Name

_____ Signature of Patient or Representative

_____ Date

Accuracy of Medical Information, Release of Medical Information and Assignment of Benefits

After filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely. I authorize and direct that payment be made directly to *Hardinsburg Chiropractic, PSC, Dr. Stefan Cesarz, 112 Bank Street, Hardinsburg, KY 40143* for any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance plan, pre-paid health care plan or medical injury payment. I understand that there is no guarantee that my insurance company(s) will cover or pay for all or any of my charges. I understand and agree that any unpaid balances not covered by my insurance plan will be paid by me. I authorize the release of any information concerning my health information and health care services which may have been acquired by examination to my insurance company(s), claims adjustor, attorney or Medicare. I authorize the release of my medical records, x-rays, diagnostic test results and other health related information to *Dr. Stefan Cesarz of Hardinsburg Chiropractic, PSC.*

_____ Patient Signature

_____ Date

Consent to Treat Minor Child

I hereby request and authorize *Dr. Stefan Cesarz, D.C.* to perform a physical examination, diagnostic testing (including x-rays if necessary) and render treatment including Chiropractic Adjustments and adjunctive therapy to _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

_____ Printed Name

_____ Signature of Representative

_____ Relationship to Minor

_____ Date

Pregnancy Warning and Consent to X-ray

I understand that if I am pregnant and have x-rays taken which exposes my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for x-ray examination. At this time, to the best of my knowledge, I am NOT pregnant and consent to having x-rays taken.

_____ Patient Signature

_____ Date

HARDINSBURG CHIROPRACTIC, P.S.C.
STEFAN CESARZ, D.C., D.A.B.F.P.
112 BANK STREET
HARDINSBURG, KY 40143
Telephone: (270) 756-1700 • Fax: (270) 756-6205 • Email: drcesarz@bbtel.com

INSTRUCTIONS TO COUNSEL

I, _____ clearly understand that all past, present and future bills incurred at **Hardinsburg Chiropractic, PSC, Stefan Cesarz, D.C.**, are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care in this office.

I also hereby irrevocably agree to have the doctor's entire bill paid from any proceeds of any nature by way of settlement, judgment or otherwise that I or you may receive. I do hereby irrevocably instruct you, _____, my attorney to pay the doctor in full from any such proceeds of settlement, judgment or enforcement of judgment actions. You are to pay the doctor prior to disbursing any proceeds to me.

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for any balance remaining.

I do hereby waive any applicable statute of limitations on the collection of my account with this office.

I instruct you, _____, my attorney not to attempt to negotiate my doctor's bill, who has provided all services billed for and I agreed to pay in full.

_____
Printed Name of Patient

_____
Patient Signature

_____
Date

Subscribed and sworn to before me, a Notary Public, this _____ day of _____, 20_____.

_____
Notary Public, State at Large
My Commission Expires: _____

Hardinsburg Chiropractic, PSC/Dr. Stefan Cesarz, DC
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information. We are also required by to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below, we will not sell or provide any of your health information to any outside marketing organization. We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment.
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.
All correspondence should be addressed to:

Hardinsburg Chiropractic, PSC
Attn: HIPPA Compliance Officer
112 Bank Street
Hardinsburg, KY 40143

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your healthcare information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc. if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. Your insurance company), if they are potentially responsible for the payment of your service.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. Test results. 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder a message will be left on your answering machine and/or mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. Appointment reminders, care alternatives, and etc.)

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organization. Any restrictions should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provided health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

We may revoke your authorization to us any time in writing. There are two circumstances under which we will not be able to honor your evocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508 (b)(5)(i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/where (i.e. Mailing address or contact number) you would like to receive information about your health or the services we provide.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven years from the date the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. According to Kentucky statue there will be a no charge for the first copy of your records. For second and subsequent copies there will be a charge of $1.00 per page copied. Copies can be made of your x-rays for a charge of $10.00 for each film. The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

1. Required for your treatment, to obtain payment for services, to run our practice, and/or made to you
2. Necessary to maintain a directory of the individuals in our facility to individuals involved with your care
3. For national security, intelligence purposes, or law enforcement offices

We will provide the first accounting within a 12 month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your rights to file a complaint and will not take any actions against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

MARKETING

Do you wish to receive our newsletter or other information regarding health matter in the mail? ( )Yes ( )No

Do you consent to allowing us to use your name on thank you boards or in our newsletters? ( )Yes ( )No

By signing, I acknowledge that I was given the opportunity to read this notice and ask questions.

Patient Name Printed _____ **Date** _____

Patient Signature _____ **Authorized Staff Person** _____

Personal Representative Printed _____ **Personal Representative Signature** _____

Description of personal representative's authority to act for this patient _____