Triad of Health, LLC // Downtown Gilbert Healthcare **New Patient Health History**

Personal Info

First Name		Last Name		Age	
Date of Birth		Email		Gender	

Height		FT.		IN.	Weight		LBS

Home Address				City		State		Zip	
Phone		Type	--	2nd Phone		Type	--		
Preferred Method of Communication		--		Permission to send text messages	☐				

Employer Information

Employer				Work Address	
City		State		Zip	

Emergency Information

Emergency Contact		Relationship		Phone	

Insurance Information

Are you Medicare Eligible?	☐	Yes	☐	No

Do you have a Health Savings Account or Flexible Spending Account?	☐	HSA	☐	FSA	☐	None	

How did you hear about our office?	
If you were referred by an existing patient, please tell us who so we can thank them:	

Primary Care Physician		Primary Care Phone	

Current Medications (Please include name and dosage. If you need more space, please provide a separate list.)
Current Supplements (Please include name and dosage. If you need more space, please provide a separate list.)

Medical & Surgical History

First Name		Last Name			
Date of Birth		Age		Gender	

Surgeries and Hospitalization

Surgeries:	☐	Less than 1 month ago	☐	1-6 months ago	☐	6-12 months ago		Yrs ago
Fractures:	☐	Less than 1 month ago	☐	1-6 months ago	☐	6-12 months ago		Yrs ago
Hospitalized:	☐	Less than 1 month ago	☐	1-6 months ago	☐	6-12 months ago		Yrs ago
If you answered yes to any of the above, please describe:								

Past Medical History (Check all that apply)

☐	AIDS/HIV	☐	Chronic fatigue	☐	Glaucoma	☐	Kidney disease	☐	Sleep apnea
☐	Alcoholism	☐	Dental problems	☐	Gout	☐	Liver disease	☐	STI
☐	Allergies	☐	Depression	☐	Headache	☐	Mental illness	☐	Stroke
☐	Alzheimer's Disease	☐	Diabetes, Type 1	☐	Heart Disease	☐	Migraine	☐	Substance abuse
☐	Arthritis	☐	Diabetes, Type 2	☐	Hepatitis	☐	Motor vehicle accident	☐	TB
☐	Asthma	☐	Digestion problem	☐	Hernia	☐	Neurological disease	☐	Thyroid problem
☐	Athlete's foot	☐	Diverticulitis	☐	Herniated disc	☐	Obesity	☐	Ulcer
☐	Autoimmune Disease	☐	Eating disorder	☐	High Blood Pressure	☐	Osteopenia	☐	UTI
☐	Blood clots	☐	Emphysema	☐	High Cholesterol	☐	Osteoporosis	☐	Varicose veins
☐	Bronchitis	☐	Epilepsy/seizure	☐	IBD/Colitis	☐	Pacemaker		
☐	Bruise easily	☐	Food intolerance	☐	IBS	☐	Pneumonia		
☐	Cancer, tumors	☐	Fused/Fixated Joints	☐	Infection, chronic	☐	Rash		
☐	Carpal tunnel syndrome	☐	Genetic disorder	☐	Jaw pain/TMJ	☐	Scoliosis		
☐	Chest pain	☐	GERD (refux)	☐	Joint replacement	☐	Skin problems		

Family Medical History (Check all that apply)

☐	Alcoholism	☐	Diabetes, Type 2	☐	Heart Disease	☐	Mental illness	☐	Substance abuse
☐	Alzheimer's Disease	☐	Eating disorder	☐	Hepatitis	☐	Migraine	☐	TB
☐	Autoimmune Disease	☐	Emphysema	☐	High Blood Pressure	☐	Neurological disease	☐	Thyroid problem
☐	Cancer, tumors	☐	Epilepsy/seizure	☐	High Cholesterol	☐	Obesity		
☐	Depression	☐	Genetic disorder	☐	IBD/Colitis	☐	Pacemaker		
☐	Diabetes, Type 1	☐	Headache	☐	IBS	☐	Stroke		

Reproductive Health History (Check all that apply)

☐	BPH	☐	Hair loss	☐	Low Libido	☐	Prostate Cancer		
☐	C-section	☐	Infertility	☐	Low mood	☐	Vaginal infection		
☐	Decreased erection	☐	Irregular periods	☐	Menopause	Other:			
☐	Decreased strength	☐	Irritability	☐	Ovarian cyst				
☐	Endometriosis	☐	Lack of energy	☐	Perimenopause				
☐	Fibroids	☐	Loss of height	☐	Pelvic inflammatory dz				

Social Health History

Tobacco use:	Current smoker	☐	Packs per day	SELE	For how long?	Selec	Non-smoker	☐	
Alcohol use:	Rarely	☐	Weekends	☐	Daily	☐	Non-drinker	☐	
When you drink, how many do you typically have?			1-2	☐	2-5	☐	5-7	☐	More than 7 ☐

Caffeine & Energy Drinks:	Never	☐	1-3x per week	☐	Daily	☐	+1x per day	☐
Exercise Habits:	None	☐	1-2x per week	☐	3-4x per week	☐	+5x per week	☐
Hours Sleep per night:	9-10 hours	☐	7-8 hours	☐	5-7 hours	☐	Less than 5	☐

Personal Info

First Name		Last Name			
Date of Birth		Age		Gender	

Height		FT.		IN.	Weight		LBS

Have you had chiropractic care before?	☐	Yes	☐	No	If yes, how long ago?	

Reason for Today's Visit

Condition History

When did your complaint(s) first begin?		Today, is the condition:	
Explain what helps and/or worsens the condition:			

Have you experienced this/ these complaint(s) before?	☐	Yes	☐	No	If yes, when?	

Are you pregnant?	☐	Yes	☐	No	If yes, how many weeks?	

Are you currently experiencing any of the following? (Check all that apply)

☐	Nausea/ Vomiting	☐	Rapid Eye Movement	☐	One-sided numbness	☐	Fainting or lightheaded	☐	Dizziness
☐	Difficulty Walking	☐	Difficulty Speaking	☐	Headache or neck pain	☐	Difficulty Swallowing	☐	Double Vision

If you answered yes to any of the above, please describe:

Where is/are your area(s) of complaint today? (Check all that apply)

Complaint	Rating 1-10 (10=worst)	Radiate	Sharp	Dull	Tingling	Numb	Burning	Inflamed	Constant	Intermittent
Head/Migraine		☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck		☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Arm(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Elbow(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Wrist(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Back		☐	☐	☐	☐	☐	☐	☐	☐	☐
Mid Back		☐	☐	☐	☐	☐	☐	☐	☐	☐
Low Back		☐	☐	☐	☐	☐	☐	☐	☐	☐
Hip(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Sciatica		☐	☐	☐	☐	☐	☐	☐	☐	☐
Knee(s)		☐	☐	☐	☐	☐	☐	☐	☐	☐
Ankle		☐	☐	☐	☐	☐	☐	☐	☐	☐

INFORMED CONSENT AND REQUEST FOR CHIROPRACTIC CARE

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains dislocations and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle and ligament strains or sprains as a result of manual therapy techniques.
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper and cervical spine adjustments and the occurrence of stroke, which may cause neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following cervical and lumbar spine adjustments or chiropractic treatment

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from Downtown Gilbert Healthcare.

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disk injuries, strokes, and paralysis.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

_____	_____	_____
Printed Name	Signature	Date

Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. Downtown Gilbert Healthcare requires payment in full at the time services are rendered. For your convenience we accept Check, Cash, Visa, MasterCard, Discover, and American Express payments, along with most Flex Spending and HSA debit cards.

INSURANCE

Chiropractic only contracted with Medicare Part B and Triwest as the primary insurance. We can submit the chiropractic claims to your insurance to determine if you have any chiropractic out of network coverage. Generally, if there is out of network coverage it will go towards your out of network deductible. If your deductible has been met, you may receive our reimbursement payment, in turn we ask that you cash the check and in turn pay Triad of Health, LLC. Whatever is not covered by your insurance, we do not pass it on to you the patient. **Naturopathic services are not covered by insurance and are cash pay.**

ATTORNEY and LIABILITY

Please understand that monthly statements and health insurance payments may be sent directly to you. If you receive a reimbursement from your insurance company you agree to sign such reimbursement over to Triad of Health, LLC for any and all charges incurred for treatment. Should my attorney fail to make payment directly to Triad of Health, LLC upon settlement of my personal injury case or no settlement is obtained. I understand and agree that I am responsible for any balance that is outstanding with Triad of Health, LLC. I will notify Triad of Health, LLC of any changes in my case, such as obtaining a new attorney; case is lost or dismissed, etc.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card/debit card, or payment by cash or check at time of services has been verified.

NO-SHOW and CANCELATION POLICY

A credit card is required to be kept on file for all of your Naturopathic appointments.

_____ I agree that I will cancel or reschedule my appointments no later than 24 business hours in advance. If I am unable to do so I agree to pay for the missed/canceled appointment ($100 for Naturopathic appointments.)

_____ I agree that if I am going to be more than 10 minutes late to my appointment, I will need to reschedule or understand my appointment time will be limited and I will be responsible to pay the full amount for the appointment.

_____ I have been informed and agree: There are multiple ways to give 24 hour notice to the office that I need to cancel or reschedule my appointment. All of the following are acceptable.

Text message to the front desk: 480-518-3681
Text message to Dr. Bradford: 480-442-7133
Phone call/voicemail to office: 480-219-6354
Email to office: info@downtowngilberthealthcare.com

_____ As a courtesy, I may receive an automated notification reminder from Triad of Health LLC via text message, email, and/or phone call prior to my appointment. I agree that I am still responsible to notify the office of cancellation through the options listed above.

I have read the financial agreement and understand that I am ultimately responsible for debt incurred for treatment at Triad of Health LLC. My insurance benefits have been explained to me and I fully understand what my insurance has verified that they will pay. I also understand verification of benefits is not a guarantee of payment and I am ultimately responsible for any balance with Triad of Health, LLC. By signing below, I have read and agreed to the Financial Agreement.

X_____ Date _____

Signature of Patient or Responsible Party

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 our organization, 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 organization, 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 equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: 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, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. 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 this organization 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.

Our organization is not required to agree to a restriction that you may request. If our organization 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, e.g., electronically.

You may have the right to have our organization 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.**

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 questions concerning or objections to this form, please ask to speak with our Provider person or by phone at 480-219-6354

Associated companies with whom we may do business such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.