Patient Information

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| --- | --- | --- | --- | --- | --- |
| **Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. | | | | | |
| **First Name:** | **Middle Name:** | | | **Nick Name:** | |
| **Last Name:** | **Suffix:** | **Previous Name:** | | | |
| **Address 1:** | | | | | |
| **City:** | **State:** | | | | **Zip Code:** |
| **Primary Phone:** | **Secondary Phone:** | | | | **Mobile Phone:** |
| **Home Email:** | | | **Work Email:** | | |
| *By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*  *Patient Signature:* | | | | | |
| **Contact Method** - **How would you like us to communicate with you?** *(check all that apply)*  ❑Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email | | | | | |
| **How did you learn about our office?**  ❑ Patient/Friend ❑ Physician ❑ Advertisement ❑ Student ❑ Community Event ❑ Sports Event  **Name of person or event:** | | | | | |

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| **Date of Birth:** | **Age:** | **Gender:** *(check one)* ❑Male ❑ Female ❑ Unspecified |
| **Marital Status** *(check one)*  ❑ Single ❑ Married ❑ Other  **Spouse’s Name**: | | |
| **Employment Status:** *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed | | |
| **Race:** *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native  ❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island ❑ Samoan ❑ Guamanian or Chamorro ❑Other ❑ I choose not to specify | | |
| **Multi-Racial:** *(check one)* ❑ Yes ❑ No ❑ Unknown | | |
| **Ethnicity:** *(check one)* ❑ Hispanic or Latino ❑Not Hispanic or Latino ❑ I choose not to specify | | |
| **Preferred Language:** *(check one)*  ❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German ❑ Vietnamese ❑ Italian ❑ Korean  ❑ Tagalog ❑ Russian ❑ Polish ❑ French ❑ Japanese ❑ Portuguese ❑ Greek ❑ Arabic ❑Creole ❑ Hindi  ❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify | | |

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| **Verification Question** *(choose only one question by checking the question, then give the answer to that question)* |
| ❑ What is the name of your favorite pet? |
| ❑ In what city were you born? |
| ❑ What high school did you attend? |
| ❑ What is your favorite movie? |
| ❑ What is your mother’s maiden name? |
| ❑ On what street did you grow up? |
| ❑ What was the make of your first car? |
| ❑ When is your anniversary? |
|  |
| **Verification Answer to the Chosen question:** *(Answers must be at least 6 characters. This allows us to email encrypted health information securely to the provided email address.)* |

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| **Emergency Contact Information**  **Full Name:** |
| **Address:** |
| **Relationship: Phone Number: ( )** |

Have you previously received chiropractic care? ❑ No ❑ Yes; if yes: date and location of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Condition**

Reason(s) for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition due to an accident / injury? ❑ Yes ❑ No ❑ Auto ❑ Work ❑ Home ❑ Other Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the mechanism of accident / injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

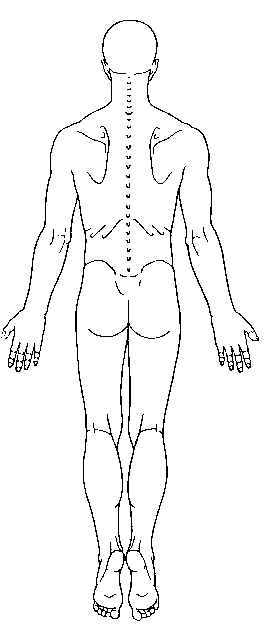
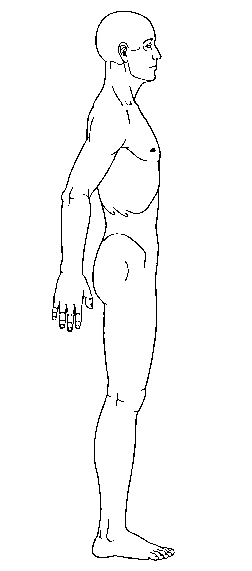
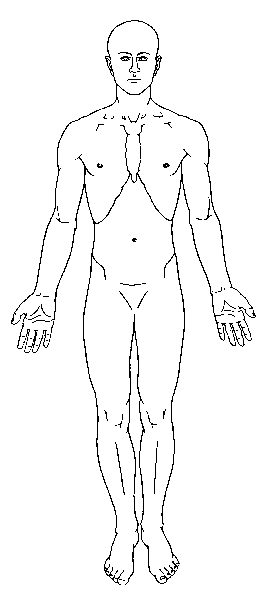
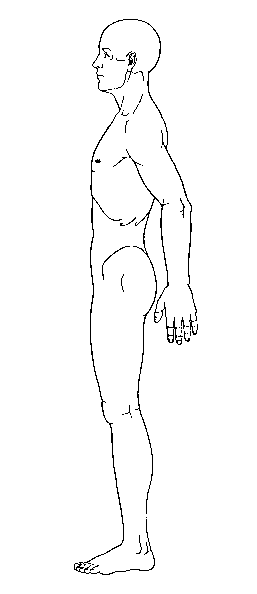
How often do you have this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long does the problem last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the pain radiate? ❑ Yes ❑ No If yes, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation?

Activities or movements that are difficult or painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

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

***Circle*** your level of pain on the below scale of ***0 to 10***:

(***At rest***) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(***With activity***) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

What time of day is your current pain/problem worse?

❑ Morning ❑ Late in the day ❑ Middle of night ❑ As day progresses ❑ N/A

My current pain/problem seems to be: ❑ Getting better ❑ Staying the same ❑ Getting worse ❑ N/A

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My current pain/problem can be described as (check all that apply):

❑ Electric ❑ Sharp ❑ Stabbing ❑ Knife-like ❑ Piercing ❑ Shooting ❑ Achy ❑ Gripping ❑ Heavy

❑ Cramp-like ❑ Burning ❑ Deep ❑ Superficial ❑ Stiffness (am >1-2 hours or PM or Both) ❑ Spasm

❑ Tearing ❑ N/A

What treatment have you already received for your condition?

❑ Medications ❑ Surgery ❑ None ❑ Physical Therapy ❑ Chiropractic Care

Name of other doctor(s) who have treated you for this condition and how \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you satisfied with the results of your treatment? ❑ Yes ❑ No Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Allergies** |
| Are you allergic to any medication(s)?  ❑ Yes ❑ No  If yes, which medications? |
| Are you allergic to any of the following?  ❑ Bee Sting ❑ Latex ❑ Peanuts ❑ Shellfish ❑ Dairy ❑ Mold ❑ Pollen ❑ Wheat ❑ Eggs ❑ Nuts  ❑ Other |
| Describe the reaction: |

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| **Smoking History** |
| Do you currently smoke tobacco of any kind?  ❑ Yes ❑ Former smoke ❑ Never been a smoker |
| If yes, how often do you smoke:  ❑ Current every day smoke ❑ Current sometimes smoker |
| If yes, what is your level of interest in quitting smoking?  ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10  No interest Very Interested |

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| **Medications** | | | | |
| Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑ | | | | |
|  | **Medication Name** | **Quantity / Dosage** (ie. 1 tablet / 5 mg) | **Frequency**  (ie. 2 times / day) | **Start Date** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |
| 7 |  |  |  |  |
| Do you currently use any recreational drugs? ❑ Yes ❑ No | | | | |

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| **Social History** |
| What job did you do during most of your life? |
| WORK ACTIVITY: |
| What is your job description? |
| What do you do most of the day at work? |
| ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Other |
|  |
| How would you describe the physical stress level at work? ❑ Low ❑ Medium ❑ High |

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| EDUCATION : |
| Mark the highest level of education completed: |
| ❑ Elementary school ❑ Middle school ❑ High School ❑ Vocational School ❑ GED ❑ Associates Degree |
| ❑ Bachelors Degree ❑ Graduate Degree ❑ Doctorate ❑ other |

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| **DIET/NUTRITION** |
| Are you on any special diet? ❑ Yes ❑ No If yes, for what reason? |
| Is your weight a concern for you emotionally or physically? ❑ Yes ❑ No |
| Have you gained or lost over 10 pounds in the past 6 months without wanting to? ❑ Yes ❑ No |
| My dietary intake consists mainly of the following: (Mark all that apply) |
| ❑ Fruits ❑ Vegetables ❑ Whole Grains ❑ High Fiber ❑ Low Fiber ❑ High Salt ❑ Low Salt ❑ High Sugar |
| ❑ Low Sugar ❑ Low Carbohydrate ❑ High Fat ❑ Low Saturated Fats ❑ High Protein ❑ Low Calorie |
| Describe your appetite: ❑ Normal ❑ Abnormal |
| How many 8 ounce glasses of water do you drink a day? |
| Alcohol Use: Now? ❑ Yes ❑ No Amount/Weekly\_\_\_\_ How long? \_\_\_\_\_ Years/Months |
| In the past? ❑ Yes ❑ No Amount/Weekly\_\_\_\_ How long? \_\_\_\_\_ Years/Months |
| How many coffee caffeine drinks do you drink a day? Cups \_\_\_\_ ❑ None |
| How many soda caffeine drinks do you drink a day? Cans \_\_\_\_ ❑ None |

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| **Health Review:**  How many hours of sleep are you getting per night? ❑ Less than 5 ❑ 6 - 8 ❑ 8 - 10 ❑ 10 or more hours  How would you rate your sleep on the following scale?  0 1 2 3 4 5 6 7 8 9 10  Wake up Fully Rested No/Poor Sleep    How many days a week do you exercise for 30 minutes or more?  ❑ 0 ❑ 1 - 2 ❑ 3 - 4 ❑ 5 - 6 ❑ 7  How would you rate the intensity of your exercise?  High Intensity 0 1 2 3 4 5 6 7 8 9 10 No Exercise  How would you rate your physical stress level?  No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed  How would you rate your emotional stress level?  No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed  List your major Stressors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What are your health goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  In addition, talk to your doctor about other areas which may be affecting your health such as worries about finances, social support, and alcohol, tobacco and/or drug use. |

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| **Personal Health History** |
| Are your currently under the care of a Healthcare Provider or any other doctor? ❑ Yes ❑ No  If yes, for what condition(s) |
| Provider’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has any doctor diagnosed you with Hypertension recently? ❑ Yes ❑ No  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has any doctor diagnosed you with Diabetes recently? ❑ Yes ❑ No  If yes, was your blood lab-work test for hemoglobin A1c >9.0% ❑ Yes ❑ No ❑ Not Sure  If yes, other comments regarding Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No |

Do you wear any of the following?

❑ Heel Lifts ❑ Innersoles ❑ Arch Supports ❑ Orthotics ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were they prescribed by a doctor? ❑ Yes ❑ No

Have you seen a chiropractor in the past? ❑ Yes ❑ No Date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, name and location of previous Chiropractor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you satisfied with your care? ❑ Yes ❑ No Why?

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure / Test** | **Date of last:** | **Procedure / Test** | **Date of last:** |
| Chiropractic Exam |  | CT-Scan |  |
| Prostate/PSA |  | Colon |  |
| Cholesterol |  | Spinal X-ray |  |
| Mammogram |  | Stool check for blood |  |
| MRI |  | Bone Density Scan |  |
| Pap Smear |  |  |  |
| Other: |  |  |  |
|  |  |  |  |

**Childhood Illnesses:**

❑ ADD ❑ depression ❑ Psoriasis ❑ atopic dermatitis ❑ diabetes ❑ Rash ❑ allergies/hayfever

❑ ear infections ❑ scoliosis ❑ anemia ❑ fetal drug exposure ❑ seizures ❑ asthma ❑ headaches

❑ sickle cell ❑ bedwetting ❑ hepatitis ❑ spina bifida ❑ cerebral palsy ❑HIV

❑ other: ❑ chicken pox ❑ measles ❑ Crohn’s/colitis ❑ mumps

**Adult Illnesses:**

❑ ADD ❑ CVA (stroke) ❑ heart disease ❑ Parkinson Disease ❑ suicide ❑ Alzheimer’s ❑ chicken pox ❑ hepatitis

❑ Unspecified pleural effusion attempt(s) ❑ arthritis ❑ cystic kidney disease ❑ HIV ❑ pneumonia ❑ thyroid

❑ asthma ❑ depression ❑ high blood pressure ❑psoriasis ❑ thyroid problems ❑ cancer ❑ diabetes

❑ influenza pneumonia ❑ psychiatric condition ❑ vertigo ❑ cerebral palsy ❑ eczema ❑ liver disease

❑ scoliosis ❑ chicken pox ❑ emphysema ❑ lung disease ❑ seizures ❑ colitis ❑ eye problems

❑ lupus ❑ shingles ❑ CRPS(RSD) ❑ fibromyalgia ❑ multiple sclerosis ❑ STD’s (unspecified)

❑ Other:\_\_\_\_\_\_

**Injuries**: (List date next to injury)

❑ back injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ fracture ❑ laceration (severe) ❑ broken bones ❑ head injury

❑ motor vehicle accident ❑ disability (ies) ❑ industrial accident ❑ soft tissue injury ❑ fall (severe) ❑ joint injury ❑ Other:

**Surgeries**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Date** | **Procedure (i.e. knee repair)** | **Description** |  |
| 1 |  |  |  | In Patient / Out Patient |
| 2 |  |  |  | In Patient / Out Patient |
| 3 |  |  |  | In Patient / Out Patient |
| 4 |  |  |  | In Patient / Out Patient |
| 5 |  |  |  | In Patient / Out Patient |

**Review of systems** (Please indicate if you have any of the following by checking the box.)

**Constitutional:** ❑ None

❑ daytime drowsiness ❑ fever ❑ night sweats ❑ chills ❑ fatigue ❑ loss of appetite ❑ weight gain / loss

**Eyes/Vision:**  ❑ None

❑ cataracts ❑ itching ❑ wears contacts/glasses ❑ blindness ❑ double vision ❑ photophobia ❑ blind spots

❑ eye problems ❑ tearing

**Ears, Nose & Throat:** ❑ None

❑ fainting ❑ history of head injury ❑ runny nose ❑ dizziness ❑ frequent sore throats ❑ loss of sense of smell

❑ sinus infection ❑ ear discharge ❑ headaches ❑ nosebleeds ❑ ear pain ❑ hearing loss ❑ nasal congestion

**Respiration**: ❑ None ❑ cough ❑ shortness of breath ❑ wheezing ❑ asthma ❑ coughing up blood

❑ sputum production

**Cardiovascular**: ❑ None

❑ high blood pressure ❑ paroxysmal nocturnal ❑ varicose veins ❑ claudication ❑ low blood pressure

❑ dyspnea (leg pain and ache) ❑ orthopnea (difficulty ❑ shortness of breath ❑ heart problem

❑ breathing lying down) with exertion ❑ heart murmur ❑ palpitations ❑ ulcers

**Gastrointestinal:** ❑ None

❑ belching ❑ difficulty swallowing ❑ jaundice ❑ abdominal pain ❑ black/tarry stool ❑ heartburn ❑ ulcers

❑ abnormal stool ❑ constipation ❑ hemorrhoids ❑ rectal bleeding (Color/consistency)

❑ diarrhea ❑ indigestion ❑ loss of bowel control

|  |  |  |  |
| --- | --- | --- | --- |
| **Female:** ❑ None or N/A | | | |
| ❑ birth control | ❑ vaginal discharge | ❑ abnormal vaginal bleeding | ❑ burning urination |
| ❑ urine retention | ❑ breast lump/pain | ❑ irregular menstruation | ❑ frequent urination |
| ❑ cramps | ❑ hormone therapy | ❑ urine incontinence |  |
|  |  |  |  |
| I … ❑ am currently pregnant ❑ am NOT currently pregnant  I … ❑ currently have menses ❑ currently DO NOT have menses | | | |
| My menses… ❑ are regular ❑ are NOT regular Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_  \_\_\_\_\_\_age of first menses  \_\_\_\_\_\_age when menopause began | | | |
| If you have been pregnant in the past, please fill in the appropriate information below.  \_\_\_\_\_\_Number of complicated pregnancies  \_\_\_\_\_\_Number of uncomplicated pregnancies  \_\_\_\_\_\_Number of C-sections  \_\_\_\_\_\_Number of vaginal deliveries  \_\_\_\_\_\_Number of miscarriages  \_\_\_\_\_\_Number of terminated pregnancies | | | |

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| --- | --- | --- |
| **Male:** ❑ None or N/A |  |  |
| ❑ burning urination | ❑ hesitancy/dribbling | ❑ erectile dysfunction |
| ❑ prostate problems | ❑ frequent urination | ❑ urine retention/incontinence |

**Sexual Health:**

Do you have any concerns about your sexual health? ❑ YES ❑ NO

Are you or have you ever been a victim of domestic or sexual abuse? ❑ YES ❑ NO

**Skin**: ❑ None

❑ Changes in skin color or texture ❑ history of skin disorders ❑ rash ❑ change in nail ❑hair loss

❑ Itching ❑ skin lesions/ulcers ❑ hives ❑ numbness ❑ varicosities

**Nervous System:** ❑ None

❑ Limb weakness ❑ seizures ❑ stroke ❑ dizziness ❑ loss of consciousness ❑ sleeps disturbance

❑ Unsteadiness of gait/loss of balance ❑ facial weakness ❑ loss of memory ❑ slurred speech ❑ headache

❑ Numbness ❑ stress

**Psychologica**l: ❑ None

❑ Bi-polar disorder ❑ depression ❑ memory loss ❑ anxiety ❑ confusion ❑ insomnia ❑ mood change

❑ Behavioral change ❑ convulsions ❑ loss or change of appetite

**Hematologic:** ❑ None

❑ bleeding ❑ blood transfusion ❑ fatigue ❑ anemia ❑ blood clotting ❑ bruising easily

❑ lymph node swelling

Please check the appropriate response. If you are not sure, check the “**?**” box.

|  |  |
| --- | --- |
| ❑ **YES** ❑ **NO** ❑ **?** | Do you have a past history of cancer? |
| ❑ **YES** ❑ **NO** ❑ **?** | Have you had any unexplained weight loss? |
| ❑ **YES** ❑ **NO** ❑ **?** | Your pain does not improve with rest? |
| ❑ **YES** ❑ **NO** ❑ **?** | Are you over 50 years old? |
| ❑ **YES** ❑ **NO** ❑ **?** | Failure to respond to a course of conservative care (4-6 weeks)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Have you had spinal pain greater than 4 weeks? |
| ❑ **YES** ❑ **NO** ❑ **?** | Prolonged use of corticosteroids (such as organ transplant Rx)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Intravenous drug use? |
| ❑ **YES** ❑ **NO** ❑ **?** | Current or recent urinary tract, respiratory tract or other infection? |
| ❑ **YES** ❑ **NO** ❑ **?** | Immunosuppression medication and/or conditions? |
| ❑ **YES** ❑ **NO** ❑ **?** | Are you currently or have you used blood thinners? |
| ❑ **YES** ❑ **NO** ❑ **?** | History of significant trauma? |
| ❑ **YES** ❑ **NO** ❑ **?** | Minor trauma in person >50 years old? |
| ❑ **YES** ❑ **NO** ❑ **?** | Do you have osteoporosis (weak bones)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Are you over 70 years old? |
| ❑ **YES** ❑ **NO** ❑ **?** | Any history of prolonged use of corticosteroids? |
| ❑ **YES** ❑ **NO** ❑ **?** | Acute onset urinary tract retention or overflow incontinence (wet underwear)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Loss of anal sphincter tone or fecal incontinence (bowel accidents)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Saddle anesthesia (numbness in the groin region)? |
| ❑ **YES** ❑ **NO** ❑ **?** | Global or progressive muscle weakness in the legs (legs give out)? |

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| --- | --- | --- | --- | --- |
| **Family History** | | | | |
| Relation | Age  (now or at death) |  |  | Serious illness/  cause of death |
| Father |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Paternal grandfather |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Paternal grandmother |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Mother |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Maternal grandfather |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Maternal grandmother |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Brother(s) |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Sister(s) |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Son(s) |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
| Daughter(s) |  | ❑ alive  ❑ deceased | ❑ no significant disease  ❑ has/had: |  |
|  |  | ❑ alive  ❑ deceased |  |  |

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at this time.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE Information**

Name of your health insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete if applicable to your current health condition:

Personal Injury Auto Accident Worker Compensation

If you have consulted an attorney, please provide attorney’s name and address:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dear Patient**:

For our records and for your convenience, please check the appropriate box for the following questions.

1. Are you a Medicare Patient? ❑ YES ❑ NO

If so, please state your secondary insurance carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you a Medicaid Patient? ❑ YES ❑ NO

3. Are you filing for a Worker’s Compensation case? ❑ YES ❑ NO

4. Are you filing for a Personal Injury case? ❑ YES ❑ NO

5. Are you a minor (under the age of 18)? ❑ YES ❑ NO

Please state the Parent/Legal Guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Records:**

Patient records, are the property of our office. These records are only released with your written permission or as required legally. Patient confidentiality is always maintained.

**Financial Matters:**

Payment is due at the time services are provided unless prior arrangements have been made. All charges will be explained to you prior to any service being performed.

**Personal Injury and Workers Compensation:**

Our office accepts Personal Injury (PIP) and Workers Compensation cases. Further paperwork and preauthorization may be required.

I have read the above statement and accept these conditions.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of Individual] consent to Sean T. Norkus, D.C. and Neuro Approach Enterprises, LLC (“the Practice”) use and disclosure of my Protected Health information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, “Protected Health Information” means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions, However; if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notices of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosure of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Chiropractor or the Practice has acted in reliance on this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, [Patient’s Name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Sean T. Norkus, D.C. and Neuro Approach Enterprises, LLC, which describe the Practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**For Office Use Only If Notice Not Provided To Patient**

The practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Patient’s name] receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

□ Patient Unavailable □ Patient Physically Unable □ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of privacy practices in the following manner (check all that apply):

□ Personally □ Mail □ Phone Follow Up □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Chiropractor

**Consent to Evaluation and Treatment of a Minor**

I, being the lawful parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, minor of the age of \_\_\_\_\_\_\_\_\_\_\_\_ do hereby give my consent, authorize, and request Sean T. Norkus, D.C. and Neuro Approach Enterprises, LLC to evaluate and to administer such treatment deemed advisable, necessary, or requested on the above mentioned child.

Parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed parent name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed witness name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD ESCORT AUTHORITY CONSENT FORM

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, make oath and say that I am the lawful Guardian of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (child’s name) a \_\_\_\_\_\_\_ year old \_\_\_\_\_\_\_\_\_\_\_\_\_ (male/female) residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and born on \_\_\_\_\_\_\_\_\_\_\_\_ (DOB) in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city), \_\_\_\_\_\_\_ (state).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s (child’s name) social security (or social insurance) number is:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SS#).

ESCORT’S AUTHORITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Escort’s name) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city, state) has my permission to consent to evaluations such as physical examinations, x-rays, other imaging techniques, diagnosis and treatments such as chiropractic adjustments and any other treatments or procedures that the attending chiropractic physicians, medical or emergency personnel deem necessary or prudent.

I am granting the permission prior to any such health care treatment, for the purpose of providing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Escort’s name) with the authority and power to exercise his or her best judgment upon the advice of the chiropractic physicians, medical or emergency personnel.

In the event of my child requiring life-sustaining or emergency treatment, I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Escort’s name) to summon any and all emergency personnel to attend, transport and treat my child and consent to physical examination (including x-rays and other imaging techniques), medical diagnosis, provision of medication or anesthetic and receipt of any other treatment that may be deemed necessary or prudent by, and provided under the supervision of, any health care professional licensed by the State of Florida.

EFFECTIVE LOCATION(S): This consent is only valid for treatment by Sean T. Norkus, D.C. through Neuro Approach Enterprises, LLC whether in person or through the use of online evaluation.

GUARDIAN CONTACT INFORMATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Legal Guardian's name) can be reached at home or work, as follows:

• Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Fax Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EFFEECTIVE DATE

This consent will take effect on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_(M/D) , 20\_\_\_\_ and continue until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M/D), 20\_\_\_\_.

Signed this \_\_\_\_\_the day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

Clinician sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal guardian sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal guardian print:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness #2 sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Escort sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness #2 print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Escort print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chiropractic Clinic Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of February 2 2018, and will remain in effect until we replace it.

CHANGES TO NOTICE: We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, and HEALTHCARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to other healthcare providers providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official’s health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS: A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary or your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment, and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Contact: Sean T. Norkus, D.C. – Compliance Officer

E-mail address: drseannorkus[@gmail.com](mailto:eapappagallo@gmail.com)

Telephone: (561) 317-3516

Privacy Official: Sean T. Norkus, D.C.

E-mail address: drseannorkus[@gmail.com](mailto:eapappagallo@gmail.com)

Telephone: (561) 317-3516

Address: 1023 Fox Trace Court, Port Orange, FL 32127

Rights of Patients Each health care facility or provider shall observe the following standards: Individual dignity 1. The individual dignity of a patient must be respected at all times and upon all occasions. 2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his or her care. 3. A patient has the right to a prompt and reasonable response to a question or request. 4. A patient has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. Information 1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. 2. A patient has the right to know what patient support services are available in the facility. 3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information. 4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal. 5. A patient has the right to know what facility rules and regulations apply to patient conduct. 6. A patient has the right to express grievances regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance. A patient who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

Financial information and disclosure

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care. 2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility. 3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. 4. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

Access to health care

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment. 2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment. 3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

Experimental research

In addition to the provisions of s. 766.103, a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

Responsibilities of Patients

• A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

• A patient has the right to a prompt and reasonable response to questions and requests.

• A patient has the right to know who is providing medical services and who is responsible for his or her care.

• A patient has the right to know what patient support services are available, including whether an interpreter is avail- able if he or she does not speak English.

• A patient has the right to know what rules and regulations apply to his or her conduct.

• A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

• A patient has the right to refuse any treatment, except as otherwise provided by law.

• A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

• A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

• A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

• A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

• A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

• A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

• A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

• A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

• A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

• A patient is responsible for reporting unexpected changes in his or her condition to the health care provider. • A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

• A patient is responsible for following the treatment plan recommended by the health care provider.

• A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying health care facility.

• A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

• A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

• A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

-Florida Patient’s Bill of Rights and Responsibilities. Florida Statutes Chapter 381(026)