Date_____
Social Security No._____
Driver's License #_____

CONFIDENTIAL PATIENT INFORMATION

Name_____ Home Phone_____ Cell Phone_____
24hr Text Message Reminder: Y or N Cell Phone Carrier: _____
Address_____ City_____ St_____ Zip Code_____
E-Mail address _____
Age_____ Birth Date_____ Marital Status: M S D W
Occupation_____ Employer_____
Employer Address_____ Work Phone_____
Insurance Company_____ ID/Member #_____
Primary Subscriber_____
Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Work Phone_____

Emergency Contact Name:_____
Address_____ Phone #: _____

How did you hear about us? _____

Have you ever suffered from:	YES	NO		YES	NO
1) Dizziness	☐	☐	8) Cancer	☐	☐
2) Headaches	☐	☐	9) Asthma	☐	☐
3) Neck Pain	☐	☐	10) Digestive Disorders	☐	☐
4) Backaches	☐	☐	11) Nervousness	☐	☐
5) Arthritis	☐	☐	12) Numbness	☐	☐
6) Heart Trouble	☐	☐	Explain_____		
7) Diabetes	☐	☐	_____		

Date of Last Physical Examination_____
Purpose of this appointment_____
Other Doctors seen for the condition_____
Has a physician treated you for any health condition in the last year? YES ☐ NO ☐
Describe_____
Please list any medications you are currently taking:_____
_____

PAYMENT IS EXPECTED AT TIME OF VISIT!
Name of person responsible for payment_____
Are you insured? YES ☐ NO ☐ Insurance Company_____
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Highlands Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Highlands Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature_____ Date_____

Is this related to:
Auto Accident Yes ___ No ___
Work Injury Yes ___ No ___

If yes, please turn over and complete!!!

Highlands Chiropractic

IF YOUR CASE IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

- Date of Accident_____Time_____Location_____
- How did the accident occur? ☐ Auto Collision ☐ On-The-Job Injury ☐ Other_____
- Please Describe the accident_____

_____

_____

- Did you report the injury to your foreman or employer? ☐ YES ☐ NO
- If yes, did he/she recommend care at out office? ☐ YES ☐ NO
- If **auto accident**, were you: ☐ Driver ☐ Passenger ☐ Pedestrian
- Were you struck from: ☐ Front ☐ Behind ☐ Driver's Side ☐ Passenger's Side
- Conditions of Roads: ☐ Dry ☐ Wet
- Did your car strike the other(s) involved? ☐ YES ☐ NO
- Did the other care strike yours? ☐ YES ☐ NO
- If airbag, did it employ? ☐ YES ☐ NO
- Position of head: ☐ Turned Left ☐ Turned Right ☐ Facing Forward
- Position of hands: Left Hand_____ Right Hand_____
- Position of feet: Left Foot_____ Right Foot _____
- List the extent of your injuries as you know them_____

_____

_____

- Did you require post-accident hospitalization? ☐ YES ☐ NO
- Have you lost any days of work due to the accident? ☐ YES ☐ NO
- Check the symptoms you have noticed since accident?

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Heavy	☐ Loss of Memory	☐ Cold Feet
☐ Stiff Neck	☐ Pins/Needles in Arms	☐ Ringing in Ears	☐ Cold Hands
☐ Sleeping Problems	☐ Pins/Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing In Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ Anxiety
☐ Chest Pain	☐ Depression	☐ Loss of Memory	☐ _____

- Insurance Companies Involved

  My Company_____ Do you have PIP? ☐ YES ☐ NO

  Company of person responsible for injuries _____
- Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ YES ☐ NO
- Do you have an attorney that has advised you in this case? ☐ YES ☐ NO

  Attorney's Name: _____

Signature_____ Date_____

Guardian Signature _____ Date_____

HIPAA Notice of Privacy Practices

Highlands Chiropractic
3901 NE 4th St., Ste #109
Renton, WA 98056
(425)277-0577

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 relate 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 your physician, 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 physician's practice, 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. One example would be if we would need to disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example would be if your protected health information would need to 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: 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: Coroners, Funeral Directors, and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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 the physician's practice 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 anticipations 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.

Your physician is not required to agree to a restriction that you may request. If physician 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 i.e. electronically.

You may have the right to have your physician 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.**

This notice was published and becomes effective on/or before **April 14, 2003.**

.....

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 objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____