

NAME _____ DATE _____ DOB _____ AGE _____

ADDRESS _____

HOME# _____ CELL# _____ EMAIL _____

GENDER _____ SS# _____ EMERGENCY CONTACT _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS (please circle) single married divorced separated widowed

SPOUSE'S NAME _____ DOB _____ EMPLOYER _____

PRIMARY CARE PHYSICIAN _____ REFERRED BY _____

CIRCLE ANY OF THE FOLLOWING THAT YOU SUFFER/SUFFERED OR BEEN DIAGNOSED

- | | | | | |
|---------------------|---------------------|-----------------------------|------------------|----------------------|
| AIDS | Cancer | High blood pressure | Rheumatic fever | High cholesterol |
| Allergies | Heart disease | Kidney disease | Scoliosis | Osteoporosis |
| Anemia | Cirrhosis/Hepatitis | Mental/emotional difficulty | Sinus trouble | Rheumatoid arthritis |
| Arthritis | Diabetes | Multiple Sclerosis | Thyroid problems | Asthma |
| Bladder dysfunction | Diverticulitis | Pacemaker | Ulcer | Inguinal hernia |
| Bowel dysfunction | Epilepsy | Migraine headaches | Stroke | Umbilical hernia |
| Bone fracture | Fibromyalgia | Prostate problems | COPD | Parkinson's Disease |
| Other _____ | | | | |

FAMILY HEALTH HISTORY _____

PREVIOUS SURGERIES AND DATE OF SURGERY _____

MEDICATION LIST (please list all medications and vitamins you currently take) _____

ARE YOU PREGNANT _____ DUE DATE _____

ALLERGIES _____

DO YOU SMOKE _____ How much _____ DO YOU EXERCISE _____ How often _____

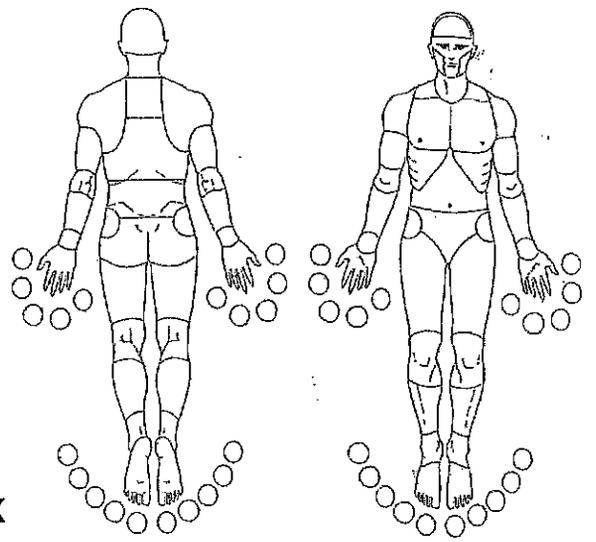
DO YOU DRINK ALCOHOLIC BEVERAGES _____ How often _____

MEDICAL AUTHORIZATION AND ASSIGNMENT OF PAYMENT

I hereby authorize the doctors of Hay Clinic of Chiropractic to release any information regarding services rendered by them and allow a photocopy of any signature to be used to file insurance. I also assign payment for benefits due me for the services rendered to be made directly to Hay Clinic regardless of my insurance benefits. I understand that if the physicians of Hay Clinic accept me as a patient I authorize them to proceed with any treatment that may be necessary. Furthermore any risk regarding chiropractic treatment will be explained to me.

PATIENT SIGNATURE _____ DATE _____

Please indicate on the diagram
the areas you are seeking treatment for
at this office and answer all questions below



NECK AND UPPER BACK

LOCATION Left side _____ Right side _____ Center _____

PAIN LEVEL (please circle) no pain 0 1 2 3 4 5 6 7 8 9 10 (excruciating)

FREQUENCY Infrequent (25%) _____ Occasional (25-50%) _____ Frequent (50-75%) _____ Constant _____

WHEN DID PROBLEM BEGIN _____ Gradual _____ Sudden _____

ARE THE SYMPTOMS GETTING WORSE _____

WORSE WHEN (please circle) moving affected area of spine prolonged sitting prolonged standing
prolonged walking performing daily activities bending sneezing coughing bowel movements lifting reaching
stooping turning twisting normal working duties transitioning positions

BETTER WHEN (please circle) lying down taking medication nothing ROM/stretching sitting standing walking
chiropractic care using heat using ice resting exercising knees to chest laying on left side laying on right side

QUALITY(please circle) ache dull sharp stabbing throbbing electric fiery shooting deep burning numb tingling

When are symptoms at their worst(please circle) morning afternoon evening during night

What do you feel caused your problem _____

Have you had these symptoms before _____ When _____

Do the symptoms interfere with: working duties _____ daily activities _____ sleep _____

Other doctors seen for this condition _____

Have you had recent x-rays/MRI or other tests performed? _____

MID TO LOWER BACK

LOCATION Left side _____ Right side _____ Center _____

PAIN LEVEL (please circle) no pain 0 1 2 3 4 5 6 7 8 9 10 (excruciating)

FREQUENCY Infrequent (25%) _____ Occasional (25-50%) _____ Frequent (50-75%) _____ Constant _____

WHEN DID PROBLEM BEGIN _____ Gradual _____ Sudden _____

ARE THE SYMPTOMS GETTING WORSE _____

WORSE WHEN (please circle) moving affected area of spine prolonged sitting prolonged standing
prolonged walking performing daily activities bending sneezing coughing bowel movements lifting reaching
stooping turning twisting normal working duties transitioning positions

BETTER WHEN (please circle) lying down taking medication nothing ROM/stretching sitting standing walking
chiropractic care using heat using ice resting exercising knees to chest laying on left side laying on right side

QUALITY(please circle) ache dull sharp stabbing throbbing electric fiery shooting deep burning numb tingling

When are symptoms at their worst(please circle) morning afternoon evening during night

What do you feel caused your problem _____

Have you had these symptoms before _____ When _____

Do the symptoms interfere with: working duties _____ daily activities _____ sleep _____

Other doctors seen for this condition _____

Have you had recent x-rays/MRI or other tests performed? _____

INFORMED CONSENT FORM

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement

Analysis / Examination / Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy palpation vital signs range of motion testing orthopedic testing basic neurological testing muscle strength testing postural analysis testing hot/cold therapy electric muscle stimulation radiographic studies mechanical traction spinal decompression vital signs laser therapy Other _____

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include:

Self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (*insert doctor's name*) and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT NAME _____

DATE _____

PATIENT SIGNATURE (Signature of Parent/Guardian if minor) _____

PATIENT/PHYSICIAN CONTRACT

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to our office. This policy reduces your out-of-pocket expense. All payments are expected at the time of service unless prior payment arrangements have been made and authorized by office manager. Fees collected will be for copays, deductibles, coinsurance, and non-covered services. Our fees are considered usual, customary, and reasonable by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. If your carrier has not paid a claim within sixty days of submission, you agree to take an active part in the recovery of your claim. You agree to provide current health insurance cards in order for this office to submit claims to the correct carrier.

If you have a personal injury claim (another person/insurance company at fault) you are ultimately responsible for payment. We will file claims with applicable parties and await payment for a reasonable period of time (up to 3 years). Your balance will be due in full as soon as the claim is settled or denied.

If you have a workman's compensation claim you are ultimately responsible for payment. We will file claims with your employer or insurance carrier but you agree to take an active part in recovery of payment.

I acknowledge that I have read and understand this policy

PATIENT NAME _____

DATE _____

PATIENT (Parent/Guardian) SIGNATURE _____

I authorize release of protected health information to:

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

I authorize text/email appointment reminders _____

Cell phone carrier _____ Phone # _____ Email _____

Hay Clinic of Chiropractic
NOTICE OF PRIVACY PRACTICES

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.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you. *Example:*

A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. **Help with public health and safety issues**

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Disclosure to Health Information Exchanges

This facility participates in the NC Health Information Exchange Network, called NC HealthConnex, which is operated by the NC Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from NC programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our office and online at NC HealthConnex.gov. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NC HealthConnex.gov/patients.