Confidential Patient Health Record

DATE	ID NO.

PERSONAL HISTORY

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Birthdate _____ Age _____ Sex: ☐ M ☐ F

Cell Phone _____

Primary Care Dr. _____ Phone _____

Social Security Number _____ E-mail _____

Business/Employer _____ Type of Work _____

Business Phone _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ No. of Children ____

Name of Spouse _____ Spouse's Birthdate _____

Name and number of Emergency Contact _____ Relationship _____

Referred to This Office by: _____

Who is Responsible for Your Bill: ☐ Self ☐ Spouse ☐ Workman's Comp ☐ Auto Insurance ☐ Medicare

☐ Medicaid ☐ Personal Health Insurance (Name) _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No Who? _____

Type of Treatment _____ Results _____

When Did This Condition Begin: _____ Has This Condition Occurred Before? ☐ Yes ☐ N

Is Condition: ☐ Job Related ☐ Auto Related ☐ Home Injury ☐ Fall ☐ Other

Date of Accident _____ Time of Accident _____

Have you Made a Report of Your Accident to Your Employer? ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear a Shoe Lift? ☐ Yes ☐ No

Do You Suffer from Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please check or Describe

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accidents or Falls _____

Hospitalization (other than above) _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Joint Pain/Stiffness
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Gas/Bloating After Meals
- ☐ Fainting
- ☐ Convulsion
- ☐ Cold/TIngling Extremities
- ☐ Stress

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-RCODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- ☐ Yes
- ☐ No
- ☐ Not sure

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Family Health History

This information is necessary in the diagnosis of your condition and may be needed for medical insurance reports. Please check the conditions which pertain to your family members.

Condition	Father	Mother	Spouse	Children
Back/Disc Prob.				
Headaches/Migraines				
Scoliosis				
Asthma-Sinus				
Pinched Nerve				
Stomach Problems				
Other:				

PAYMENT ARRANGEMENTS ARE EXPECTED BEFORE SERVICES ARE RENDERED:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 at this office, any outstanding charges for professional service rendered me will be immediately due and payable. I authorize the release of any medical information necessary for payment of my claim. I authorize direct payment of medical benefits to Bethel Park Chiropractic Clinic.

Patient's Signature _____ Date _____

PERSON RESPONSIBLE FOR PAYMENT

BETHEL PARK CHIROPRACTIC CLINIC, INC.
NOTICE OF PRIVACY PRACTICES/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.
Bethel Park Chiropractic Clinic, Inc. is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Understanding your Healthcare Record/Information

Each time you visit our clinic, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnosis, treatment and recommended plan for future treatment. This health or medical record, serves as, but is not limited to the following:

1. Legal document describing the care you received.
2. Basis for planning your care and treatment.
3. Means of communication to other healthcare professionals who contribute to your care.
4. Means by which you or a third-party payor can verify that services billed were actually rendered.
5. A tool in which we can use to continually work to improve the quality of your care.

Understanding what your healthcare record is and how your health information is used helps you to:

1. Ensure it's accuracy.
2. Better understand who and why others may need to access your health information
3. Make more informed decisions when authorizing disclosure to others

Your Healthcare Record/Information Rights

Although your healthcare record is the physical property of Bethel Park Chiropractic Clinic, Inc. the information belongs to you. You have the right to:

1. Obtain paper copy of notice of information practices upon request.
2. Request restriction on certain uses and disclosures of your healthcare information.
3. Inspect and copy your healthcare record.
4. Obtain accounting of disclosures of your healthcare information.
5. Revoke your authorization to use or disclose your healthcare information except to the extent that action may have already been taken.

Bethel Park Chiropractic Clinic Inc.'s Responsibility to You:

1. Maintain the privacy of your healthcare information.
2. Accommodate reasonable requests you may have to communicate your healthcare information to other healthcare providers.
3. Provide you with a notice of our legal duties/privacy practices with respect to your healthcare information we collect and maintain regarding your care.
4. Abide by the terms of this notice.
5. Notify you if we are unable to agree to a requested restriction.

Bethel Park Chiropractic Clinic, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Bethel Park Chiropractic Clinic, Inc. is required by law to comply with this Notice. We will not disclose your healthcare information without your authorization except as described in this notice.

If you have any questions or if you feel your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer-Debbie W. at 412-835-0636. There will be no retaliation for filing a complaint.

Bethel Park Chiropractic Clinic, Inc.
5727 Library Road
Bethel Park, PA 15102
(412) 835-0636

Privacy Notice Acknowledgement

This is to acknowledge that I have received and have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Bethel Park Chiropractic Clinic, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (Print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date