

A T L E E C H I R O P R A C T I C C E N T E R

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire in black ink only. Your answers will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____
How do you wish to be addressed in our office? ☐ First Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.
Address: _____ City: _____
State/Zip code: _____ Date of Birth: mm ____ dd ____ yr ____ Marital Status: ☐ Married ☐ Single
Home Telephone: _____ Business Telephone: _____
Cellular Telephone: _____ e-mail address: _____
Employer: _____ Address: _____
Occupation: _____ Hobbies: _____
Spouse's Name: _____ Children's Names: _____
Children's Names: _____ Children's Names: _____
How did you hear about our office? _____

HEALTH INFORMATION

Have you ever been to a chiropractor before? ☐ Yes ☐ No
If so, what was the reason? _____
Have you had previous healthcare for this problem? ☐ Yes ☐ No
If yes, where? _____ When? _____

REASON FOR CONSULTING OUR OFFICE

☐ I have a specific problem and require help only with this problem.
☐ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.
☐ After my specific problem has been resolved and I understand methods to ensure it does not return,
I am interested in strategies to improve my general health.
☐ I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.
What is/are your major complaint(s)? _____
How long have you had this condition? _____
Is this injury: ☐ Work Related? ☐ Motor Vehicle Accident? ☐ Not Applicable
Have you had this or similar conditions in the past? ☐ Yes ☐ No If yes, when? _____
What activities aggravate your condition? _____
What makes it better? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____
How long has it been since you really felt well? _____

(Please complete both sides)

List surgical operations and/or major injuries: _____

List any prescription drugs, over the counter drugs, vitamins and natural supplements you currently take: _____

Are you wearing ☐ Heel Lifts ☐ Sole Lifts ☐ Inner soles ☐ Arch support ☐ Orthotics

Have you been in an auto accident: ☐ Never ☐ Recently ☐ Past year ☐ Past 5 years or more

Describe the accident: _____

Have you had any other personal injury or accident: ☐ Never ☐ Recently ☐ Past year ☐ Past 5 years or more

Describe: _____

Date of most recent physical examination: _____

Family History:

- | | | | |
|--|---|--|---|
| ☐ Anemia | ☐ Diabetes | ☐ High Blood Pressure | ☐ Prostate Problems |
| ☐ Arthritis | ☐ Exzema | ☐ Hypoglycemia | ☐ Psoriasis |
| ☐ Cancer | ☐ Emphysema | ☐ Lumbago | ☐ Rheumatoid Arthritis |
| ☐ Chronic neck pain | ☐ Epilepsy | ☐ Migraine Headache | ☐ Scoliosis |
| ☐ Chronic back pain | ☐ Heart Problems | ☐ Multiple Sclerosis | ☐ Spine Surgery |

PLEASE MARK THE AREAS OF PAIN AND/OR DISCOMFORT ON THE FIGURES BELOW:

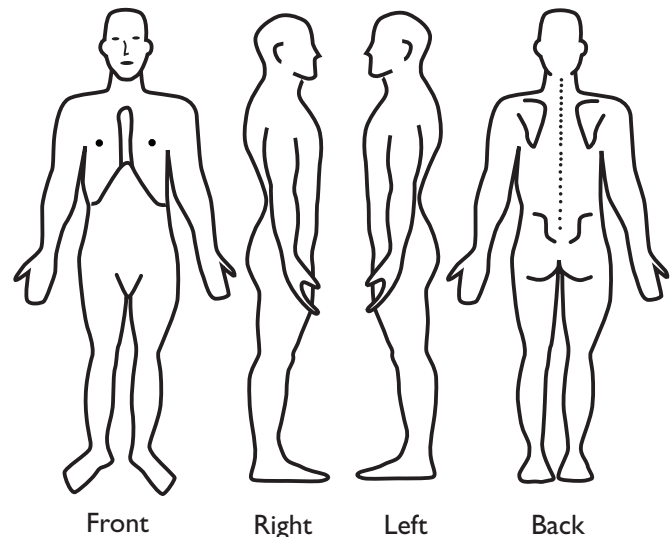
Mark an **X** on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

- | | | |
|------------------------------------|-----------------------------------|------------------------------------|
| ☐ Sharp | ☐ Dull | ☐ Throbbing |
| ☐ Numbness | ☐ Aching | ☐ Shooting |
| ☐ Burning | ☐ Tingling | ☐ Cramps |
| ☐ Stiffness | ☐ Swelling | ☐ Other |

How often do you have this pain? _____



Are you affected by any of the following? Please check: O = Occasionally F = Frequently C = Constantly

- | | O | F | C | | O | F | C | | O | F | C |
|-------------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|----------------------------|
| Asthma | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ | Heartburn | ☐ | ☐ | ☐ |
| Backache | ☐ | ☐ | ☐ | Sinus trouble | ☐ | ☐ | ☐ | Migraines | ☐ | ☐ | ☐ |
| Neck pain | ☐ | ☐ | ☐ | Digestive upset | ☐ | ☐ | ☐ | High blood pressure | ☐ | ☐ | ☐ |
| Allergy | ☐ | ☐ | ☐ | Constipation | ☐ | ☐ | ☐ | Females Only: | | | |
| Earache | ☐ | ☐ | ☐ | Dizziness | ☐ | ☐ | ☐ | Painful menstruation | ☐ | ☐ | ☐ |
| Sore throat | ☐ | ☐ | ☐ | Shoulder pain | ☐ | ☐ | ☐ | PMS | ☐ | ☐ | ☐ |
| Foot pain | ☐ | ☐ | ☐ | Leg pain | ☐ | ☐ | ☐ | Are you pregnant? | Y | ☐ | N ☐ |

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____

HIPAA Notice of Privacy Practices

Atlee Chiropractic Center
9173 Atlee Road, Mechanicsville, VA 23116
804-730-7010

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 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. 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 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, employee review, training of medical students, licensing, fundraising, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer 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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Atlee Chiropractic Center Payment Agreement

Payment: Your insurance policy requires our office to collect payment for copays and deductible amounts at time of service. Not adhering to these terms could be a violation of our contract with your insurance company and risk reimbursement for services provided. We can accept payment from you in the form of cash, credit card or check (returned checks are subject to a fee.)

Benefits: We verify benefits as a courtesy to you, however, our office does not accept responsibility for any incorrect information given by your insurance carrier regarding coverage and the copays or deductible payments for which you are responsible. As a courtesy, we bill your insurance company for their portion of your billed services. Please feel free to ask us questions once you receive the "Explanation of Benefits" (EOB) from your insurance provider.

A note about maintenance care: Your doctor will determine your initial course of treatment. After you are released from this Active treatment phase, you will be moved to Maintenance. More and more health insurance companies don't see maintenance chiropractic care as medically necessary - *even if you have visits remaining on your plan*. They prefer to only pay for treatments that help people recover from a specific illness, injury or other situation, but not for treatment after someone hits a plateau and stops showing signs of improvement. Once your doctor determines you have reached this phase, usually by performing an exam, our staff can discuss the many options available to you to continue chiropractic care at our office.

Please verify that you understand your financial responsibility by signing and dating below.

Patient Signature: _____

Print Name: _____ Date: _____

Staff Initials: _____