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Welcome to Health Solutions Physical Medicine and the Los Angeles Pain Laser Center.

Our highest priority is to provide you with an integrated natural approach to finding **Solutions** for your better **Health**.

In order to do this we require that you fill out the paperwork to the best of your ability so we can have all of your pertinent information. This paperwork may be more comprehensive than other offices you have been to in the past. This is because we strive to be more thorough than other offices and determine if and how we can help you. All information is kept strictly confidential according to HIPAA guidelines. Social Security # may be necessary for insurance or other payment purposes.

If you have health insurance you may present your insurance card to the receptionist. We may need to copy your card and driver's license so as to verify if your insurance covers any of our services, as many plans cover chiropractic, physical therapies, laboratory and diagnostic testing, X-Rays, and massage therapy. Class IV Deep Tissue Laser is not covered by insurance.

Please Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions:

1. Are you interested in finding out if conservative methods can help your problems? Y \_\_\_ N \_\_\_

2. If drugs and/or surgery can be avoided is that an approach you are willing to try first? Y \_\_\_ N \_\_\_

3. What do you plan on gaining from your visit with our office today?

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4. What gains in your overall health would you like to see in the future?

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5. Please list anyone else (friends, family, co-worker) that you feel is needlessly suffering from a problem, requires medical attention, or can be healthier than they are now?

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6. Do you have Medicare insurance Y \_\_\_ N \_\_\_

7. Are you currently:

Involved in a Worker's Compensation Y \_\_\_ N \_\_\_

Involved in a Personal Injury case Y \_\_\_ N \_\_\_

Believe you are, or may be pregnant? Y \_\_\_ N \_\_\_

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# Health Questionnaire

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ # Hours/Week Currently Working: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

## Check off any of the following symptoms you have experienced in the past 6 months:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Low Back Pain                     | <input type="checkbox"/> Shoulder Pain R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/>     | <input type="checkbox"/> Tired/Fatigued         |
| <input type="checkbox"/> Pain between Shoulder Blades      | <input type="checkbox"/> Numbness/Tingling in Arms/Hands   | <input type="checkbox"/> Difficulty Sleeping    |
| <input type="checkbox"/> Neck Pain/Across Top of Shoulders | <input type="checkbox"/> Numbness/Tingling in Legs/Feet  | <input type="checkbox"/> Allergies              |
| <input type="checkbox"/> Tension/Headaches                 | <input type="checkbox"/> Pain in the legs/feet   | <input type="checkbox"/> Digestive Problems     |
| <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> Pain in the Knees R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> | <input type="checkbox"/> Carpal Tunnel Syndrome |

OTHER (explain) \_\_\_\_\_

Which of the above is the worst? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

How often does it occur? \_\_\_\_\_

What does it feel like?(describe) \_\_\_\_\_

What have you done that has helped this problem? \_\_\_\_\_

What activities would you like to do if this was not a problem? \_\_\_\_\_

### Does this cause you to be:

- Moody
- Irritable
- Interrupt sleep
- Restricted in your daily activities

### Does this affect your work:

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day
- Unable to work long hours

### Does this affect your life:

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or sports
- Interferes with ability to do hobbies or other activities

### What have you tried to help relieve/get rid of this problem and how much did it help? ( circle appropriately)

- |   |   |
|---|---|
| ◆ Medications...Helped: Little Some Much      | ◆ Exercise...Helped: Little Some Much   |
| ◆ Physical Therapy...Helped: Little Some Much | ◆ Nutrition...Helped: Little Some Much  |
| ◆ Chiropractic...Helped: Little Some Much     | ◆ Stretching...Helped: Little Some Much |

OTHER \_\_\_\_\_

Insurance (Circle One): PPO HMO Not Applicable Carrier: \_\_\_\_\_

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

How did you hear about us? \_\_\_\_\_

**Application For Patient Care**

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male / Female  
Primary Care Physician: \_\_\_\_\_  
Do we have permission to contact your doctor regarding your care in our office? \_\_\_\_Yes \_\_\_\_No  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Type of Tasks Performed/Common Movements: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor  
Spouse's Name: \_\_\_\_\_ # of Children? \_\_\_\_\_ Children's Ages: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

**ACCIDENTS**

Have you had an auto accident? (X if applies):  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
Had a recent fall/other accident? (X if applies):  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
Have You Ever Received Chiropractic Care?  Yes  No Last Visit? \_\_\_\_\_; # Visits this year? \_\_\_\_\_  
Have You Ever Received Physical Therapy?  Yes  No Last Visit? \_\_\_\_\_; # Visits this year? \_\_\_\_\_

**REFERRALS**

How Did You Hear About This Office?  Existing Patient: \_\_\_\_\_  
 Walk-In/Drive-By  Radio: \_\_\_\_\_  
 Health Lecture  Internet: \_\_\_\_\_  
 Gym: \_\_\_\_\_  Ad: \_\_\_\_\_  
 Employee/Teacher Appreciation: \_\_\_\_\_  Community Event: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  Other: \_\_\_\_\_

**INSURANCE**

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_  
Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

***Assignment and Release (insured patients)***

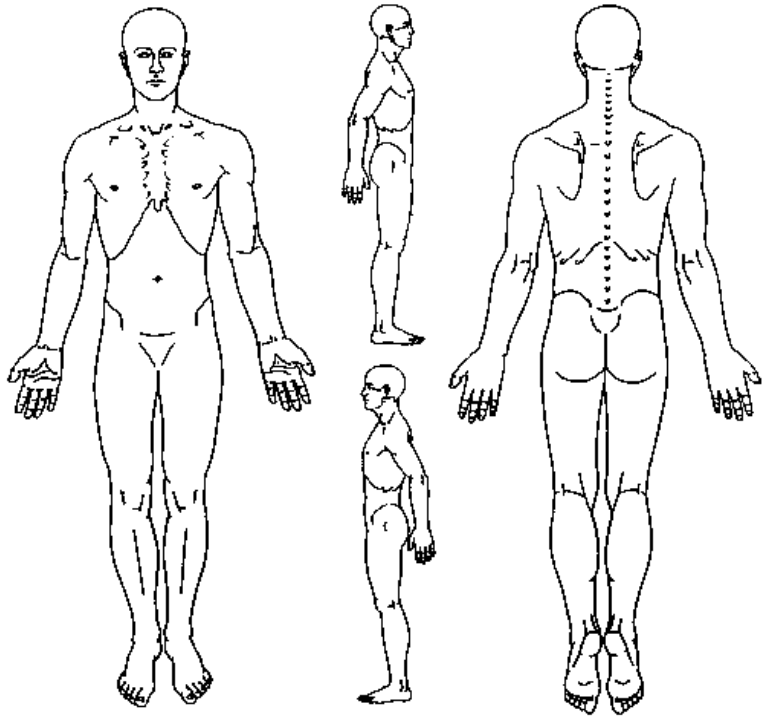
I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, *Health Solutions Physical Medicine*, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

## PATIENT HEALTH HISTORY

*Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:*

- |  |  |
|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Arms  |
| <input type="checkbox"/> Back Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Legs  |
| <input type="checkbox"/> Arm/Hand Pain         | <input type="checkbox"/> Light Bothers Eyes    |
| <input type="checkbox"/> Leg/Knee Pain         | <input type="checkbox"/> Recent Weigh Change   |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Loss of Memory        |
| <input type="checkbox"/> Night Pain            | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Loss of Taste         |
| <input type="checkbox"/> Cold Extremities      | <input type="checkbox"/> Fatigue               |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension               |
| <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats           |
| <input type="checkbox"/> Fainting              | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach Problems      | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Blurred/Double Vision |
| <input type="checkbox"/> Swollen Joints        | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Mood Changes          | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Foot Trouble          | <input type="checkbox"/> Loss of Balance       |



*Please check if you have ever had any of the following:*

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD                             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Mouth Sores or Bleeding Gums | <input type="checkbox"/> Sexual Difficulty  |
| <input type="checkbox"/> Aids/HIV                             | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Heart Problems         | <input type="checkbox"/> Multiple Sclerosis           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism                           | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots                        | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Nosebleeds                   | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Colon Trouble       | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> TMJ Pain           |
| <input type="checkbox"/> Anorexia                             | <input type="checkbox"/> Contacts/Glasses    | <input type="checkbox"/> Herniated Disc         | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Appendicitis                         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Parkinson's Disease          | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Pinched Nerve                | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Asthma/Wheezing                      | <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> Hormone/Gland Problems | <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Bad Breath/Bad Taste                 | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Polio                        | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Bleeding Disorders                   | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Prostate Problems            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Pressure: High or Low (circle) | <input type="checkbox"/> Gall Bladder        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Prosthesis                   | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump                          | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles                | <input type="checkbox"/> Psychiatric Care             | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Broken Bones                         | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Menopausal Prob.       | <input type="checkbox"/> Rheumatoid Arthritis         | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Bulimia                              | <input type="checkbox"/> Gout                | <input type="checkbox"/> Miscarriage            | <input type="checkbox"/> Scarlet Fever                | _____                                       |
|   | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Mononucleosis          |   | _____                                       |

Are you currently under medical care or taking prescription drugs for this problem?  Yes  No  
If yes, explain \_\_\_\_\_

Please list any and all medications you are currently taking: \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Office Use Only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Cancer \_\_\_\_\_  Arthritis \_\_\_\_\_  Other \_\_\_\_\_

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

• I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. will give complete and accurate information during my exam.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

### X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

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

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because:

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

Date of last menstrual period: \_\_\_\_\_

Office Use Only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please include details.

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____  | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____                                     | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____   | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____                                     | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____  | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____   | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____                                      | NO | YES |
| 8. Do our legs or feet fall asleep regularly?<br>Comment: _____   | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____  | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____  | NO | YES |
| 11. Do have frequent falls or find that you trip over your feet while walking?<br>Comment: _____                                    | NO | YES |
| 12. Have you tried any medications such as anti-inflammatory?<br>If yes, what kind of medication?<br>_____                          | NO | YES |
| 13. Have you tried any Physical Therapy or Chiropractic treatments before?<br>If yes: When? For how long? What kind?<br>_____       | NO | YES |
| 14. Have you had an MRI?<br>If yes: When? Who ordered it? What was it ordered for?<br>_____   | NO | YES |
| 15. Have you used any splint or braces or other prescribed treatment by an MD?<br>If yes: When? What kind? Who ordered it?<br>_____ | NO | YES |
| 16. If you have tried any treatment or medications, did this make your problem better?<br>Comment: _____                            | NO | YES |

Office Use Only: For any yes answer, rule in/out the diagnosis with these two tests:

- |                  |       |       |           |               |              |
|------------------|-------|-------|-----------|---------------|--------------|
| A) NCU/EMG tests | Upper | Lower | Indicated | Not Indicated | (circle one) |
| B) Vascular Test |       |       | Indicated | Not Indicated | (circle one) |

Office Use Only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Health Solutions Physical Medicine. (Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I wish to receive an electronic copy of Privacy Notice.

My email address is: \_\_\_\_\_ @ \_\_\_\_\_

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

\_\_\_\_\_ I acknowledge that it is the policy of Health Solutions Physical Medicine to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Jeffrey Katlein, about my concerns.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Office Staff)

\_\_\_\_\_  
Date

Office Use Only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## CONSENT TO CARE

**A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.**

**I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.**

**I have read and understand the foregoing.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**



Office Use Only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now***.

**SECTION 1--Pain Intensity**

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

**SECTION 2--Personal Care (Washing, Dressing etc.)**

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

**SECTION 3--Lifting**

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

**SECTION 4 --Reading**

- A. I can read as much as I want to with no pain.
- B. I can read as much as I want with slight pain.
- C. I can read as much as I want with moderate pain.
- D. I cannot read as much as I want because of moderate pain.
- E. I cannot read as much as I want because of severe pain.
- F. I cannot read at all.

**SECTION 5--Headache**

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

Office Use Only: Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**SECTION 6 -- Concentration**

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

**SECTION 7--Work**

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

**SECTION 8--Driving**

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain.
- C. I can drive my car as long as I want with moderate pain.
- D. I cannot drive my car as long as I want because of moderate pain.
- E. I can hardly drive my car at all because of severe pain.
- F. I cannot drive my car at all.

**SECTION 9--Sleeping**

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

**SECTION 10--Recreation**

- A. I am able engage in all recreational activities with no pain at all.
- B. I am able engage in all recreational activities with some pain.
- C. I am able engage in most, but not all recreational activities because of pain.
- D. I am able engage in a few of my usual recreational activities because of pain.
- E. I can hardly do any recreational activities because of pain.
- F. I cannot do any recreational activities at all.

Office Use Only: Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### HIPAA Notice of Privacy Practices and Release

*THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

**PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care as a patient at Health Solutions Center, we may need to use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (if they are, or may be, responsible for the payment of your services).
- Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with another member of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances:
  - If we are providing health care services to you based on the orders of another health care provider.
  - If we provide health care services to you in an emergency.
  - If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
  - If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
  - If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive care from us. We may also mail information to you regarding your health care, insurance forms or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information.

Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and to protect the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice and/or our privacy practices, or would like further information about our privacy policies and practices please contact us at the above numbers.

This notice is effective as of April 16, 2003. This notice, and any alterations or amendments made thereto, will expire seven years after the date upon which the record was created.

Privacy: You may be receiving treatment in the form of chiropractic adjustments and therapies which may be performed in an “open bay” setting where other patients may observe the treatment that is being rendered to you unless you otherwise request treatment in a private location.

Disparagement: Patient agrees that they will not make any derogatory statements, either oral or written, or otherwise disparage HSPM et al., or HSPM, its agents, patients, services, work, and/or employees, and will take all reasonable steps to prevent others from making derogatory or disparaging statements on their behalf. The Parties agree that it would be impossible, impractical or extremely difficult to fix the actual damages suffered by reason of a breach of this paragraph, and accordingly hereby agree that five-thousand dollars (\$5,000) shall be presumed to be the amount of damages sustained by reason of each such breach, without prejudice to the right of HSPM to also seek injunctive or other equitable relief.

**PLEASE READ THIS DOCUMENT CAREFULLY! PLEASE DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY. THE PATIENT HAS FULLY READ THIS AGREEMENT AND THE SUPPLEMENT HERETO, AND HE/SHE UNDERSTANDS THEM AND AGREES TO ABIDE BY ALL OF THE TERMS HEREOF.**

\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT)

\_\_\_\_\_  
GUARDIAN SIGNATURE

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
GUARDIAN NAME (PLEASE PRINT)

Date \_\_\_\_\_

Date \_\_\_\_\_