ABUNDANT HEALTH
CHIROPRACTIC

Name:_____ Nickname: _____Date:_____

Street Address:_____

City: _____ State: _____ Zip: _____

Home: - - Work: - - Cell: - -

Cell Phone Carrier_____ (Text Message Reminders)

Contact Preference: □ Home □ Work □ Cell

E-Mail Address:_____

(will not be shared)

Female: ☐ Male: ☐ Age:_____ Birth date:_____

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Spouse's name: _____

SSN: _____ - _____- _____ Emergency Contact info_____

Employer:_____

Employer's Address:_____

Occupation: _____

Whom may we thank for referring you?_____

Reason for Seeking Chiropractic Care

What concerns do you feel the doctor can address for you?

_____

_____

_____

Is this concern affecting any of the activities below? (Please check)

Work:	Yes ☐ No ☐	Love Life:	Yes ☐ No ☐	Sleep:	Yes ☐ No ☐
Social Life:	Yes ☐ No ☐	Walking:	Yes ☐ No ☐	Sitting:	Yes ☐ No ☐
Exercise:	Yes ☐ No ☐	Eating:	Yes ☐ No ☐	Recreation:	Yes ☐ No ☐

Have you seen a chiropractor before? Y☐ N☐ With Whom? _____

Date of last visit:_____Why did you stop care?_____

Do you have a family medical doctor? Y☐ N☐ Who?_____
Do you consult him/her regularly? Y ☐ N☐ If so, why?_____

Date of last medical consultation and result:_____

For Women: Date of last menstrual cycle:_____

Health, Wellness, and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nervous system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

Review of Systems

Please check conditions or symptoms you currently have, or have had in the past:

☐ AIDS/HIV	☐ Chemical Dependency	☐ Herpes	☐ Pinched Nerve
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Polio
☐ Arthritis	☐ Goiter	☐ Jaw Pain/TMJ	☐ Prosthesis
☐ Asthma	☐ Gout	☐ Kidney Disease	☐ Psychiatric Care
☐ Blood Clots	☐ Heart Disease	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Breast Lumps	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Bronchitis	☐ Hernia	☐ Osteoporosis	☐ Thyroid Problems
☐ Cancer	☐ Herniated Disc	☐ Pacemaker	☐ Tuberculosis

General Physical Trauma

Most trauma occurs in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

☐ automobile
☐ motorcycle
☐ sports
☐ bicycle
☐ other

If yes, please explain how and when:

_____
_____
_____

Have you ever injured your spine (neck, head, back, hips)? Y☐ N☐
If yes, please explain how and when:

_____
_____
_____

Have you ever broken any bones or sprained any part of your body? Y☐ N☐
If yes, please explain how and when:

_____
_____
_____

Have you ever been hospitalized? Y☐ N☐
If yes, please explain how and when:

_____
_____
_____

History of Chemical Stress

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated? Y☐N☐
Have you been exposed to?
☐Chemicals ☐Fumes ☐Dust ☐Smoke

Do you or have you ever taken?
☐Prescription drugs ☐Over the counter drugs ☐Recreational drugs

Do you consume?
☐Alcohol ☐Coffee/caffeine ☐Tobacco

List Current Medications:_____
Any Medications Previously taken for more than 6 months?_____

History of Emotional Stresses

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below.

Childhood trauma	Yes ☐ No☐	Work or School	Yes ☐ No☐	Lifestyle Change	Yes☐ No ☐
Loss of loved one	Yes ☐ No☐	Divorce/Separation	Yes ☐ No☐	Parents' divorce	Yes☐ No ☐
Relationships	Yes ☐ No☐	Financial	Yes ☐ No☐	Illness	Yes ☐No ☐
Family	Yes ☐ No☐	Abuse	Yes ☐ No☐	Other	Yes ☐No ☐

Quality of Life

How do you grade your physical health?	☐Good	☐Fair	☐Poor
How do you grade your emotional/mental health?	☐Good	☐Fair	☐Poor
How do you rate your overall "quality of life"?	☐Good	☐Fair	☐Poor

Consent to Chiropractic Services

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.
I, _____ have read and fully understand the above (print name).

Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Female Patients

I hereby certify that to the best of my knowledge, I am not pregnant and the doctor has my permission to take x-rays of me. Initial _____

Do you have implants of any kind? Yes☐ No☐

Financial Policy

Abundant Health Chiropractic requires payment in full for all services rendered at the time of your visit. The company generally accepts payments from the sources identified below. Please read and understand our policy as it applies to your particular situation. If you have questions feel free to ask a staff member.
PRIVATE PAY (NO INSURANCE) The fee for a new patient paying out of pocket should not exceed $185.00, which includes the initial consult, a thorough chiropractic exam, x-rays, an x-ray report read by a Board certified radiologist, and if applicable, the first adjustment.
INSURANCE If your insurance company covers Chiropractic care and you would like us to assist you in the billing process please fill out the "insurance permission" section below.

As a courtesy to you we will bill your insurance company. Please be advised that the insurance contract is between you and the carrier, it is your responsibility to keep the account current. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 90 days, payment is still not received your credit card will be charged and the insurance will pay you directly. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:
"I authorize Abundant Health Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."
"I authorize payment be made directly to Abundant Health Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: _____ Date _____

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: _____ Subscriber's date of birth: _____

PAYMENT POLICY Any fees for services rendered will be immediately due and payable if you suspend or terminate care. After 90 days your credit card will be charged and insurance will pay your directly. If an account is delinquent you will be subject to additional collections fees and interest. (Past due account will be sent to collections after 90 days). I understand that I am responsible for any charges and fees from the collections agency.

Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read, understand & agree to financial policies for Abundant Health Chiropractic.

Signed_____ Date_____

Witness_____ Date_____

ABUNDANT HEALTH
CHIROPRACTIC

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Abundant Health Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We require 24 hour notice to cancel an appointment. Any missed appointments without notice will result in a $10 fee.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publicly thank you on our office announcement board.
- We would like to be able to refer others to speak with you about your experience at Abundant Health Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Abundant Health Chiropractic.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Abundant Health Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Abundant Health Chiropractic's *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

Patient name printed	Date
Patient Signature	AHC representative

NOTICE OF PRIVACY PRACTICES:

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. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include exams and therapy.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting written requests to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1st, 2018 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Service
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)