PATIENT INTRODUCTION CARD

Eagle Bend Chiropractic. P.C.

No.: ____________________ Date: ____________________

Name (Mr. Mrs. Miss. Ms.): ______________________________ Phone: ____________________
(Last, First, MI)

Address: ____

Married: _____ Single: _____ Other: _____ Age: _____ Date of Birth: ______________

Occupation: ____________________________ Employer: ________________________________

Cell Phone: ____________________________ Office Phone: ______________________________

Email Address: ______________________________________

Previous Chiropractic Care: ________ Yes ________ No Dr's Name: ________________

Name of your Insurance Company: ____

Major Complaint: __________________________________ Social Security No: _____________

Who (or what source) Referred You: ____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

PATIENT PERSONAL/CONFIDENTIAL DATA

No. ______ Date: ______

Patient: ______ Date of Birth: ______

Home Address: ______ City: ______ State: ______ Zip: ______

Social Security No.: ______ Home Phone: ______ Work Phone: ______

Employer: ______ Address: ______

Name of Spouse: ______ SS No.: ______ No. of Children: ______

Spouse's Employer: ______ Address: ______

How did you learn of this clinic? ______

Nearest relative not living with you? ______ Phone: ______

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Other ______

PATIENT'S INSURANCE

Name of Company: ______

Address: ______

ID & Group No.: ______

Phone No.: ______

SPOUSE'S INSURANCE

Name of Company: ______

Address: ______

ID & Group No.: ______

Phone No.: ______

Purpose of this appointment and list your complaints: ______

Date of illness: ______ Time: ______ ☐ AM ☐ PM Location: ______

How did accident occur? ☐ Auto ☐ On the job ☐ Other, ______

Please describe the circumstances and what makes the condition(s) better or worse: ______

Other Doctor seen for this condition: ______

Have you been treated by a Doctor for any health condition in the last year? ☐ Yes ☐ No

If yes, please describe: ______

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: ______ Signature Patient: ______

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-RAY studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient's Signature: ______

Parent or Guardian's Signature: ______

Eagle Bend Chiropractic, P.C.

HEALTH QUESTIONAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: ____________

Patient ______________________________ **No.:** ____________

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT? ☐ **YES** ☐ **NO**

GASTRO-INTESTINAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

☐ NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse

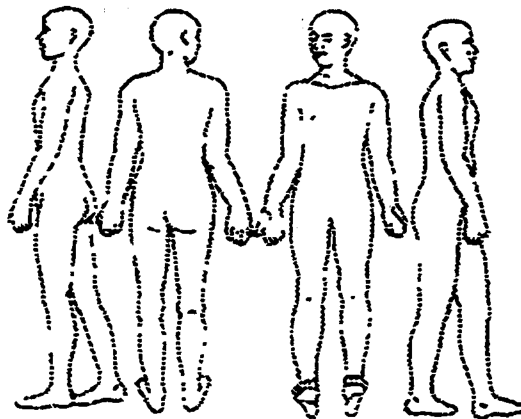
CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflamation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

SYMPTOM LOCALIZATION



P __ Pain
N __ Numb
S __ Spasm
T __ Tender
H __ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

____

Patient's Signature ______________________

* * * * * * * * * * **DO NOT WRITE BELOW THIS LINE** * * * * * * * * * *

____

____

____

____

Patient Accepted? ☐ Yes ☐ No Doctor's Signature ______________________

Eagle Bend Chiropractic, P.C.

EAGLE BEND CHIROPRACTIC, P.C.

DR. MICHAEL W. HARTMAN, D.C.

22775 E. AURORA PKWY, UNIT C-4, AURORA, CO 80016
PHONE: 303.680.2500 FAX: 720.870.5172

Office Procedures

Appointment Reminders: Your chiropractor and members of the practice or staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.
Best Contact Number:_______________

Authorization for Payment: Your chiropractor and members of the practice or staff may need to disclose your name, address, phone number, billing information, and your clinical records to your Insurance Company, Lawyers, Third Party Insurance Company or the credit bureau. This discloser will be made if we need their assistance to receive reimbursement for your services or we need their assistance because the party responsible for reimbursing your service has improperly processed your claim. By signing this form you are giving us authorization to send them this information. You are also giving them authorization to redisclose your information to the party responsible for payment of your service, the association's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Referral Board: If you refer a friend, family member or colleague into our offfice, we would like to put your name on our referral board thanking you for sending him/her to our office. By signing this form you are giving us authorization to display your name on the board.

Financial Arrangement: We have an open front desk and all of our financial arangements are discussed at the front counter. Please notify the office staff or doctor if any arrangements need to be made.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on this disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions are binding on us.

I authorize you to use or disclose my health information in the manner described above. I also acknowledge that a copy of the ofice procedures will be provided to me upon request.

_____________________________ _______________

Patinet Name Printed Date

____

Patient Signature

Patient Consent Form

I understand that I have certain rights to privacy regarding my health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1 Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2 Obtaining payment from third party payers (e.g. my insurance company);
2 The day–day health operations of your practice.

I have also been informed of, and given the right to review and secure a copy of *The New Federal HIPAA Laws,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most currant copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is being used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ______________ Day of ____________, in the year _________

Patient's Name (printed) ____

Patient's Signature ____

Practice Name: **Eagle Bend Chiropractic P.C.**

Practice Address: **22775 E. Aurora Parkway, Unit C-4**
Aurora, CO 80016

Practice Phone: **(303) 680 2500**

The New Federal HIPAA Laws

How your health information may be used:

***To Provide Treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

***To Obtain Payment:** We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

***To Conduct Health Care:** OPERATIONS- Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compOliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

***In Patient Reminders:** Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

***Abuse or Neglect:** We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

***Public Health and National Security:** We may be required to disclose federal officials or military authorities health information necessary to complete and investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

***For Law Enforcement:** As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

***Family, Friends and Caregivers:** We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

***To Coroners, Funeral Directors and Medical Examiners:** We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

*Medical Research: Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

***Authorization To Use Or Disclose Health Information:** Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization, in writing, any time.

Patient Rights

This new law is careful to describe that you have the following rights to your health information:

***Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

***Confidential communications:** You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mail communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

***Inspect and Copy your Health Information:** You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

***Amend Your Health Information:** You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

***Documentation of Health Information:** You have the right to ask for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedure will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee to duplicate and assemble your copy.

***Request A Paper Copy Of This Notice:** You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the forms of our notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information .Please let us know of your concerns or complaints in writing.

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