Patient initials: _____**-retaining *page 1 of 2***

Comprehensive Chiropractic & Physical Therapy
NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of Comprehensive Chiropractic & Physical Therapy Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient's Signature	Date	
_____	_____	
Witness	Date	

Comprehensive Chiropractic & Physical Therapy

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call at (210) 545-1810 If she/he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Comprehensive Chiropractic & Physical Therapy

Informed Consent

REGARDING: Chiropractic Adjustments, Physical Therapy Methods, Modalities, & Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at (Insert Practice Name) have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

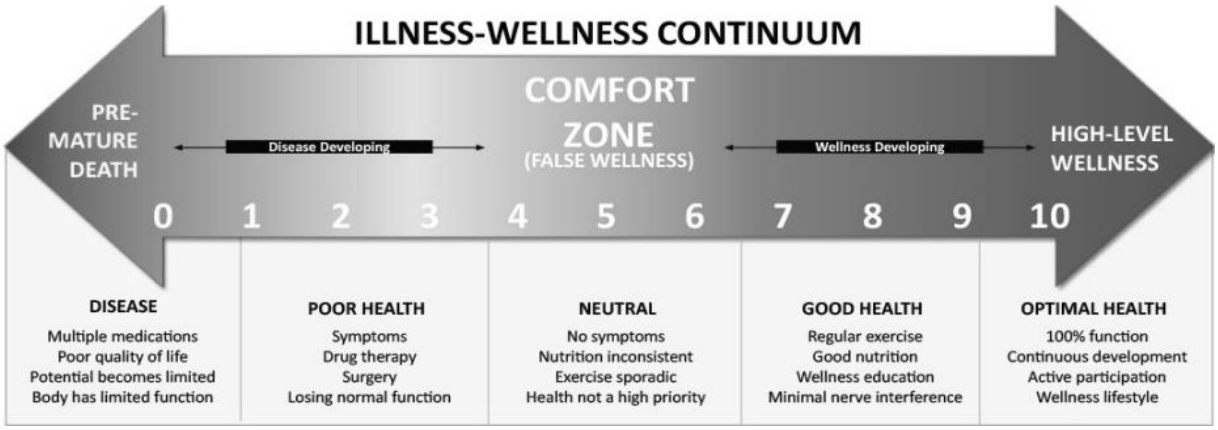
☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

Patient Wellness Assessment



What number do you think represents your health today? _____

In what direction is your health going today? _____

Are you currently at your "ideal" body weight? _____

If not, have you had trouble losing/gaining weight? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

Children & Pregnancy

How many children do you have? _____

Children's age? _____

Children's health concerns? _____

Are you currently pregnant? Yes No

Number of past pregnancies? _____

Pregnancy health concerns _____

Health & Illness History (Circle all that apply)

Cardiovascular Issues	Headaches/Migraines	Shoulder Issues	Hand/Elbow/Wrist Issues
Cancer	Heart Disease	Stroke	Foot/Ankle Issues
Anxiety	Hepatitis	TMJ Issues	Surgeries:
Arteriosclerosis	Hip Issues	Osteoporosis	_____
Arthritis	Multiple Sclerosis	Thyroid Issues	_____
Asthma/Allergies	Neck Pain	Diabetes	Other:
Back Pain	Scoliosis	Depression	_____
			_____
			_____

Is your problem the result of ANY type of accident Yes No

Allergies, Medications, & Supplements

Allergies: _____

Medications: _____

Supplements: _____

APPLICATION FOR CARE AT Comprehensive Chiropractic & Physical Therapy

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____

Cell Phone: _____

Email: _____

Sex: M F Age: _____ Date of Birth: ____-____-_____

Who is your primary care provider? _____

Who may we thank for referring you: _____

Occupation: _____

Employer: _____

Spouse Name: _____

Spouse employer: _____

IN CASE OF EMERGENCY

Name: _____

Relationship: _____

Phone Number _____

How can we help you?

What brings you in today? Primary: _____Secondary: _____

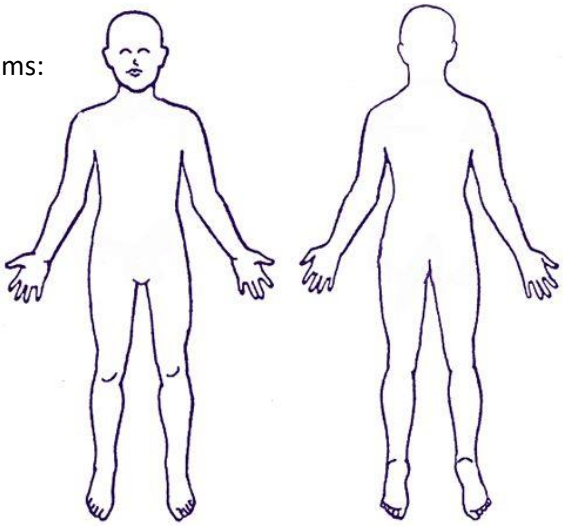
Third: _____ Fourth: _____

What symptoms, if any, are you experiencing? _____

How intense are your symptoms? **0** (No Symptoms) **1 2 3 4 5 6 7 8 9 10** (Intense Symptoms)

When did your symptoms begin? _____

Please circle, on the figure, the areas where you are experiencing your symptoms:



How did the injury occur? _____

Have you had this treated in the past? If so, by who? _____

What do your symptoms feel like?

- ☐ Numbness
- ☐ Cramping
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Sharp
- ☐ Swelling
- ☐ Burning
- ☐ Throbbing
- ☐ Other _____

_____

_____

Impact of Your Symptoms

How are your symptoms interfering with your life?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other_____	☐	☐	☐	☐

How committed are you to correcting this issue? **0 1 2 3 4 5 6 7 8 9 10**