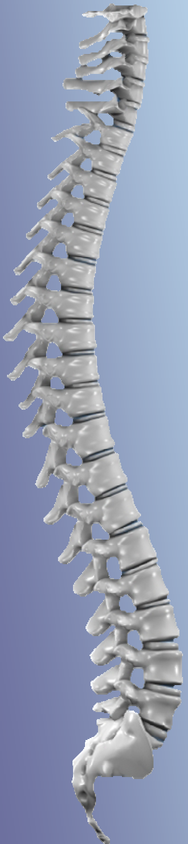
HOOD FAMILY CHIROPRACTIC CENTER

Welcome to our office!

It is our pleasure to serve you today. Please complete this form and return it to a member of our staff:

It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop significant health disorders later in life.



Name ______________________________ Home Phone ______________________

Address ____________________________ Work Phone ______________________

City, State, Zip _______________________ Cell Phone ______________________

E-mail Address ____

Birth date ______________ Age _______ SS# ______________________________

Occupation _________________________ Employer ________________________

Marital Status: M W Sep. D Sin. Spouse Name ____________ No. of Children ____

MY PURPOSE FOR TODAY'S APPOINTMENT IS:

(Please check all that apply to you)

☐ I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.

☐ I'm here for an evaluation because I'm having health challenges and am looking for a natural health solution.

☐ I'm here for an evaluation. I am curious to know if my spine is healthy and to see if I have any problems that I don't know about.

☐ I am here for an evaluation because I'm curious to learn more about Chiropractic Care.

☐ I am here for an evaluation only.

☐ Other ____

IF THE DOCTOR(S) FEEL THAT THEY CAN HELP YOU:

(Please check the one that best applies to you)

☐ I am willing to follow the doctor's recommendations because I strongly value my health.

☐ I am willing to receive care if payment plans are available.

☐ I am willing to receive care but only if my insurance pays for <u>all</u> of it.

☐ I am not interested in receiving any care.

1. Many patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Family Member or Friend's Name ____

   □ Telephone Call   □ Yellow Pages   □ Sign   □ Website   □ Presentation   □ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? ____ □ NEVER

3. When was your last complete spinal examination including x-rays? ______________________ □ NEVER

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   □ YES   □ NO   ____

5. Spinal misalignments cause decay and degeneration which may result in grinding or cracking noises. Do you ever hear noises or feel grinding when you move your head or neck?   □ YES   □ NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine?   □ YES   □ NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

   Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

   Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.

   a. _________________________ b. __________________________ c. __________________________

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. Please list the medications are you currently taking and why you are taking them. (Ex. Vicodin for Back Pain) ____

    ____

    ____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?

    □ YES   □ NO   Date of Incident ____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant?

    □ YES   □ NO   ____

13. Have you ever been diagnosed with cancer?   □ YES   □ NO

    Type __________________________________ Year Diagnosed _______________________________

The above information is true and accurate to the best of my knowledge.

Patient Signature____   Date______________________

Hood Family Chiropractic Center

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

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.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

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 God-given ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, 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 that 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. **OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, ______________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

(Signature) (Date)

Consent to Treatment of Minor Child

I hereby authorize Hood Family Chiropractic Center to administer treatment as they so deem necessary to my

daughter / son / other, ______________________________ (name)

Date: ______________________ Signed: ____

Witness: ____

Hood Family Chiropractic Center

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: ____________________________________ ID Number: ______________________

Persons/organizations providing the information:
____
____
____

Person/organizations receiving the information:
____
____
____

Specific description of information (including date(s)):

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1.The provider must complete the following statement:
   a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation exchange for using or disclosing the health information described above? Yes_______ No_______

2. The patient must read and initial the following statement:
   a. I understand that I get a copy of this form after I sign it. Pt. Initials:________

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on _ _/_ _/_ _ _ _ (DD/MM/YYYY) Initials:_____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials:______

____ __________________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing)

Printed name of patient's representative: ____

Relationship to the patient: ____

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
You may not use this form to release information for treatment or payment except
When the information to be released is psychotherapy notes or certain research information

Patient Consent for Use and Disclosure
Of Protected Health Information

[HOOD FAMILY CHIROPRACTIC CENTER]

I hereby give my consent for [HOOD FAMILY CHIROPRACTIC CENTER] (hereinafter referred to as the "Practice") o use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

[DANIELLE HOOD], our Privacy Officer, at the following address:

[5990 54th AVENUE NORTH, KENNETH CITY FL. 33709]

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice my mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________________________ ________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

Referral Board Consent

[HOOD FAMILY CHIROPRACTIC CENTER]

The undersigned hereby agrees to accept all conditions set forth in this limited consent and release.

I, the undersigned, hereby give **[Hood Family Chiropractic Center]** specific permission to post my name on the referral board in acknowledgement for referral of new patients.

The Permission granted here excludes any health care related data, and is strictly limited to the use of my name in acknowledgment of referring a new patient to the practice.

By signing this limited consent and release form I, the undersigned, represent that I am over 18 years of age. (If under 18, a parent's signature is required.)

____
Signature of Patient or Legal Guardian (If patient is under 18)

____________________________________ _________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian (If patient is under 18)

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Hood Family Chiropractic Center

I, ______________________________________ have read a copy of Hood Family
(Patient name)

Chiropractic Center's Notice of Patient Privacy Practices.

____________________________________ ______________
Signature of Patient or Parent **Date**
Legal Guardian