COAKLEY CHIROPRACTIC & ACUPUNCTURE

Please complete this form and bring it to your first appointment

PATIENT INFORMATION

Today's Date: _____

Name _____ Age _____

Date of Birth _____ Sex M F

Parent's names (if you are under 18) _____

Address _____

City _____State _____ ZIP _____

E-Mail Address _____

Occupation _____

Marital Status (Circle) S M D W L/W

Spouse/Partner's Name _____

Whom may we thank for referring you to our office?

_____

INSURANCE INFORMATION

Insurance Company _____

Subscriber ID # _____ _____ Group # _____

Subscriber Name _____

Subscriber's DOB _____ Relationship to patient _____

Is there an additional Insurance plan? Yes No

Insurance Company _____

Subscriber ID # _____ Group # _____

Subscriber Name _____

Subscriber's DOB _____ Relationship to patient _____

If this visit is due to an accident please circle type: Auto Work Other

Auto/WC Insurance Company _____

Claim # _____

Attorney Name & # (if applicable) _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Which is the best # to reach you? _____

Do we have permission to: (please circle)

Leave a message on your answering machine at home? Yes No

Leave a message on your cell phone? Yes No

Leave a message using your e-mail address at home Yes No

Signed: _____

/N CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Best number to reach them at (Circle) Home Cell Work

Number # _____

Date: _____

REASON FOR SEEKING CARE

Reason for Visit _____

When did your symptoms begin?_____

Is this condition getting progressively: (circle one) Worse Better Same

Describe the type of pain (circle) Sharp Dull Achy Burning Shooting Other

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

Is the pain constant or does it come and go? _____

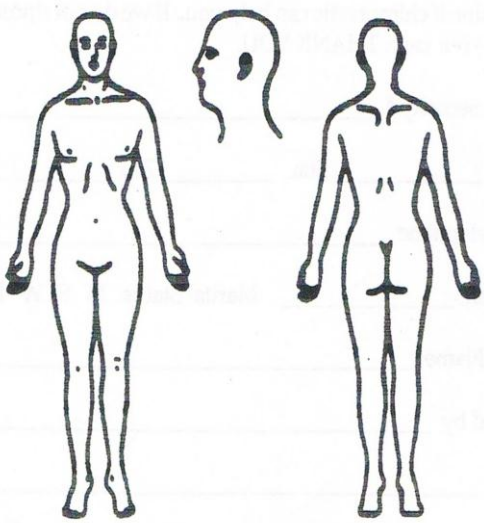
Do you have any pain, numbness/tingling into your arms or legs? _____

Mark an X on the picture where you are having pain, numbness or tingling

Does this pain interfere with your (circle) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle) Sitting Standing Walking Bending Lying Down

Please mark your areas of pain on the figures below.



Health History

Name & Phone # of Primary Care Physician _____

List other providers who have treated this condition _____

List all medications/supplements that you are currently taking _____

_____

_____

_____

List all past surgeries, injuries, accidents including auto accidents and work related accidents: _____

_____

_____

Have you had in the past or do you presently have:

- ☐ Arthritis
- ☐ Backache
- ☐ Blood clots or phlebitis
- ☐ Diabetes
- ☐ Difficult bowel movements or urination
- ☐ Dizziness
- ☐ Fractures
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Organ Transplants
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate problems
- ☐ Prosthesis
- ☐ Recent weight change
- ☐ Rheumatoid Arthritis
- ☐ Seizure disorders
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tumors/growths

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.164.508(b)(5)(i)
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at

Coakley Chiropractic & Acupuncture
9 Evergreen Street
Medway, MA 02053

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

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

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

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

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Coakley Chiropractic & Acupuncture
9 Evergreen Street
Medway, MA 02053

To contact us

If you would like further information about our privacy policies and practices please contact:

Coakley Chiropractic & Acupuncture
9 Evergreen Street
Medway, MA 02053
508-533-6794

Patient Authorization

Please complete this form and bring it to your 1st appointment

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims. I also authorize payment of medical benefits to Coakley Chiropractic & Acupuncture.

Signed: _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Coakley Chiropractic & Acupuncture will prepare any necessary reports and forms to assist me in collecting my benefit from my insurance carrier and any amount paid directly to Coakley Chiropractic & Acupuncture will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Payment for "your part" is expected at the time of service unless other arrangements are made. We accept payment in the form of cash, check, Visa or Mastercard for your convenience. Your signature below indicates that you understand and accept this policy.

Signed: _____ Date: _____

At times our office may need to contact you with appointment reminders, emergency cancellations, information about treatment or other health related information. Do we have permission to:

Leave a message on your answering machine at home?	Yes	No
Leave a message on your cell phone?	Yes	No
Leave a message using your e-mail?	Yes	No

Signed: _____ Date: _____

Privacy Notice Acknowledgement

We 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 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 the *Notice of Privacy Practices for Protected Health Information*

_____ _____

Patient (or Personal representative) Signature Date