

## Confidential Patient Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_ Preferred pronoun: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Number of Children \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Marital Status: Married Single Widow Divorced

Occupation: \_\_\_\_\_ Dominant Hand: \_\_\_Right \_\_\_Left \_\_\_Both

Email: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Is it okay to email you? Y / N Is it okay to leave voice messages? Y / N Is it okay to send texts? Y / N

Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work#: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell# ( ) \_\_\_\_\_ - \_\_\_\_\_

**\*\*Please circle your preferred contact number**

Emergency Contact: \_\_\_\_\_ Contact # ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Injury: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Did you receive treatment anywhere? If so, where? \_\_\_\_\_

\_\_\_\_\_

Surgeries? If so when/where? \_\_\_\_\_

\_\_\_\_\_

Are you on any medications? If so, please list them: \_\_\_\_\_

\_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Number: \_\_\_\_\_

**\*\*Please provide a copy of your card and a photo ID to the front desk. Thank you.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Description of Symptoms : (Check off or Circle your symptoms in the sections below.)

<input type="radio"/>	Headaches	<b>Left</b>	<b>Right</b>	<b>Both Sides</b>	<b>Type of Pain:</b>	<b>List ALL that</b>
		Front of Head				<b>Apply from</b>
		Top of Head				<b>List below</b>
		Back of Head				
<input type="radio"/>	Jaw	Left	Right	Both Sides		
<input type="radio"/>	Eye	Left	Right	Both Sides		
<input type="radio"/>	Neck	Left	Right	Both Sides		
<input type="radio"/>	Upper Back	Left	Right	Both Sides		
<input type="radio"/>	Mid Back	Left	Right	Both Sides		
<input type="radio"/>	Low Back	Left	Right	Both Sides		
<input type="radio"/>	Chest	Left	Right	Both Sides		
<input type="radio"/>	Abdomen	Left	Right	Both Sides		
<input type="radio"/>	Ribs	Left	Right	Both Sides		
<input type="radio"/>	Buttocks	Left	Right	Both Sides		
<input type="radio"/>	Shoulder	Left	Right	Both Sides		
<input type="radio"/>	Upper Arm	Left	Right	Both Sides		
<input type="radio"/>	Forearm	Left	Right	Both Sides		
<input type="radio"/>	Hand	Left	Right	Both Sides		
<input type="radio"/>	Knee	Left	Right	Both Sides		
<input type="radio"/>	Hip	Left	Right	Both Sides		
<input type="radio"/>	Leg	Left	Right	Both Sides		
<input type="radio"/>	Foot	Left	Right	Both Sides		
	<b>TYPES OF PAIN:</b>	Dull	Sharp	Aching	Cutting	Shocking
		Throbbing	Burning	Numbing	Tingling	Cramping
		Spasm	Stinging	Shooting	Pounding	Constricting
	Other types of pain:	_____	_____	_____	_____	_____

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT'S STATEMENT OF PRIVACY RIGHTS

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

**This notice takes effect on \_\_\_\_\_ and remains in effect until we replace it.**

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice. PLEASE REVIEW TO CAREFULLY.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be \$0.10 per page.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associated such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be released to any person without a signed consent from patient.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. The practice shall provide Personal Health Information to require parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf) and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administers HIPAA, with questions or to file a complaint at Toll Free: 1-877-696-6775 or Email: [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

**PATIENT'S AFFIRMATION OR RECEIPT OF  
PATIENT'S STATEMENT OF PRIVACY RIGHTS**

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

Print Name: \_\_\_\_\_

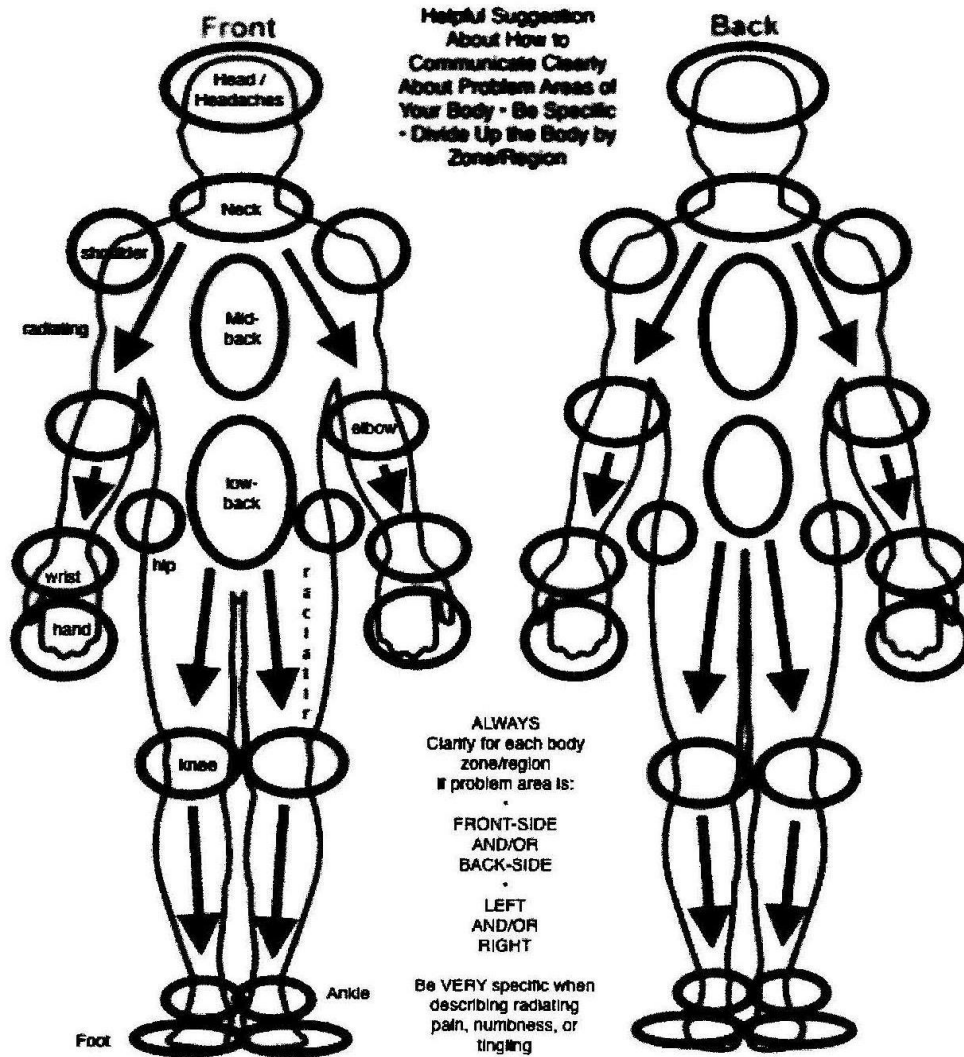
Birth Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Please list a pain scale for affected areas from 0-10 with ten being the worst pain you can imagine.**

### Pain rating scale



Right

Left

Left

Right

## Informed Consent

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment and any alternatives to the treatment. There are some risks that may be associated with chiropractic manipulation and massage treatments in particular you should note:

A. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

B. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment though no scientific study has ever demonstrated such injuries are cause, may be caused, by spinal or soft tissue manipulation or treatment.

C. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known t cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion result in paralysis or death. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government report and multi-disciplinary studies conducted over many years which have demonstrated it to be highly effective in treatment for spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. Musculoskeletal care contributes to your overall wellbeing. The risks of injuries or complications from treatment is substantially lower than associated with many medical or other treatments, medications, and procedures given the same symptoms.

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to call my present and future care with North Florida Rehab and Chiropractic, LLC.

**Dated this (month)** \_\_\_\_\_ **day of** \_\_\_\_\_ **20** \_\_\_\_\_

**Patient Printed Name:** \_\_\_\_\_

**Patient Signature (or legal guardian):** \_\_\_\_\_

**Dr. Laura W. McChesney D.C.**

**Physician Signature:** \_\_\_\_\_