Batavia Chiropractic LLC

Emerson S. Taylor, D.C., D.I.B.C.N.

Instructions for Completing the New Patient Intake Forms

Thank you for downloading the new patient intake forms. These instructions will help you to fill out the forms more completely and ensure your first visit is not as time-consuming. If you have any questions, please r back to this sheet for clarification. If you are unsure as to the accuracy of the information, leave it blank, and we will discuss it when you arrive for your consultation.

- Accuracy is extremely important. Fill this information in while you are in a quiet and comfortable location. Being relaxed helps you think more clearly, and will aide in your recall of the necessary information. Accuracy helps the doctor to fully know what has occurred in the past, giving him a more complete clinical picture of your case, and aides in formulating the best care plan for you.
- You have a choice of either printing the forms out and filling them in my hand, or you can use the PDF-fillable version, which you can either print and bring with you OR email to the office directly. Either method is acceptable.
- There are 6 pages to this intake packet. The pages that require a signature from you are pages 1, 2, These sections are to be left blank on the fill-in and the PDF-fillable versions. Please wait until your consultation to sign the forms in front of the doctor
  PLEASE NOTE: If the patient is a minor (under 18 years of age), a parent or guardian must attend the first visit / consultation with them and must sign where appropriate in order for the patient to receive treatment.
- Please bring your driver's license and insurance information with you to your appointment. This information wi be copied and verified as quickly as possible. Fill out the appropriate insurance information on the first page a
- When you fill out your name and the date on page 1, those 2 pieces of information will carry over to every ot page, so you do not need to fill-in that information on every pa
- Do not worry about the "file number" element. This will be assigned to you at the time of your consultation.
- Pain questionnaires help us assess your pain level and percentage of disability. These forms are not in this packet, but may be given to you at the time of your consultation.
- On page 4, the top portion is the "Review of Systems." Please fill in every box with the appropriate letter:
  "C" for currently experiencing; "P" for experienced in the past; "N" for never experienced
  There are 2 blank boxes at the bottom right for any other conditions you may want to notify us
- On page 4, the bottom portion is the "Daily Activities." Only **1 to 3** activities that are being affected are needed. If you can do all activities without much pain or restriction, you are welcome to leave this portion blan
- On page 6 at the bottom is a portion entitled "Communications." This portion allows this office to know who we can communicate with regarding your care via HIPAA guidelines. Please mark all applicable parties we may communicate with. If you do not indicate any certain person or persons, we must automatically presume that your wish is that we do not discuss your health information with anyone
- Also on page 6 is a portion that asks if we may contact you via email and/or text. This is to verify appointments and for email education, like newsletters, etc. that the office sends to patients. Please indicate 'yes' or 'no' for
- page 7 is the "Additional Information Sheet." This is for any other pertinent information that could not be filled in on any other intake form. You may use this form liberally or not at all, it just gives you more space to nc the office/doctor of other information that may be important for us to know.
- If you choose to print the pages, please print them one-sided, not double-sided. This will make it easier for doctor to review your information with you during your consultation.

Confidential Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SS#: _____ ❑ Male Email: _____

Date of Birth: _____ ❑ Female Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Ethnicity: ❑ Caucasian ❑ African ❑ Asian ❑ Alaskan-Native Primary Language: ❑ English - ❑ Other: _____

Employer: _____ Occupation: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to, or the result of, an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ____ Yes ____ No

PRIMARY INSURANCE (name): _____ **SECONDARY INSURANCE (name):** _____

Ins. Phone #: _____ Ins. Phone #: _____

I.D. #: _____ I.D. #: _____

Group #: _____ Group #: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Primary Care Physician ❑ *I do not have a primary care physician.*

Dr.'s Name: _____ Office Phone: _____

Addres: _____ May we send your health information to this provider?

City: _____ State: _____ Zip: _____ ❑ Yes ❑ No

Emergency Contact Information

Name: _____ Home Phone: _____

Addres: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ May we send your health information to this person

Relationship: _____ if the need arises? ❑ Yes ❑ No

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to ***Batavia Chiropractic, LLC*** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____ _____

File # Signature of Insured / Guardian Date

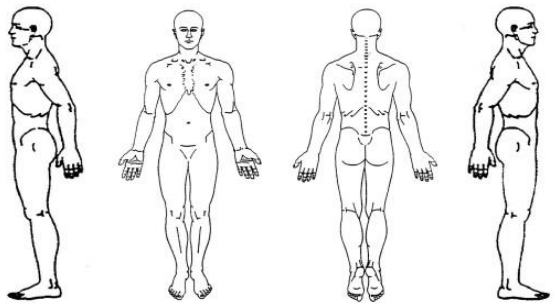
Case History

Patient Name: Date: File #:

1.) Circle the Severity (0 = No Pain, 10 = Very Severe Pain) and Frequency (% of the day you experience pain)

Condition / Problem	Severity (Minimal → Very Severe)	Frequency (% of the Day) (Occasional → Constant)
a.)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b.)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c.)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d.)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain) →



2.) ***Describe your symptoms:*** ❑ Achy ❑ Burning ❑ Cramping ❑ Dull ❑ Grinding ❑ Numb ❑ Pins/Needes ❑ Pressure ❑ Pulling ❑ Radiating ❑ Sharp ❑ Sore ❑ Stabbing ❑ Tender ❑ Throbbing ❑ Tight ❑ Tingling

3.) ***Have you experienced these symptoms before?*** ❑ Yes ❑ No

If 'yes', how long ago?: _____

4.) ***When & How did your symptoms begin?*** *(onset date & describe)* _____

_____

5.) ***My symptoms are worse during:*** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ All day

6.) ***During the day, my pain:*** ❑ Increases ❑ Stays the Same ❑ Decreases

7.) ***Does the pain radiate (travel):*** ❑ Yes ❑ No *If 'yes' where?:* _____

8.) ***Since it began, my symptoms have:*** ❑ Improved ❑ Stayed the Same ❑ Worsened

9.) **Mark the things that make your problem(s) worse:** ❑ Bending ❑ Twisting ❑ Carrying Groceries ❑ Climbing Stairs ❑ Dressing ❑ Driving ❑ Exercising ❑ Extended Computer Use ❑ Getting In/Out of Bed ❑ Grasping / Holding Items ❑ Housework (dishes, laundry, sweep, mop, vacuum) ❑ Lifting ❑ Prolonged Sitting ❑ Prolonged Standing ❑ Reading / Concentration ❑ Intimacy w/ Spouse ❑ Shaving ❑ Sit <--> Stand ❑ Sleep ❑ Turning / Bending the Head / Neck ❑ Using Arms Overhead ❑ Using Arms Outstretched ❑ Walking ❑ Washing / Bathing ❑ Work Duties ❑ Yardwork ❑ W

10.) **Mark the things that make your problem(s) better:** ❑ Sitting ❑ Resting ❑ Laying Down ❑ Ice / Heat ❑ TENS ❑ Stretching ❑ Exercise ❑ Chiropractic ❑ Massage ❑ Physical Therapy ❑ OTC Med.s ❑ Rx. Med.s ❑ Rx. Injections

11.) ***Have you been treated for this problem before?*** ❑ Yes ❑ No How long ago? _____

12.) ***What treatment did you receive?*** _____ Results? ❑ Good ❑ Fair ❑ Poor

13.) ***Were you referred to our office by anyone?*** _____

14.) ***Is the complaint(s) interfering with:*** ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

15.) *Other problems, injuries, etc. not mentioned on this questionnaire?* Use the 'Additional Information Sheet' at the end of this packet please.

I certify that the information I have provided above is accurate to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

I certify that I have reviewed the patient's information provided above. _____ (Emerson S. Taylor Jr., D.C., D.I.B.C.N.)

Batavia Chiropractic L.L.C. ● 25 North Market Street ● Batavia ● OH ● 45103 ● P: (513) 515-4937 ● F: (844) 692-7290

Review of Systems

MARK ALL PORTIONS - "C" for currently experiencing, "P" for experienced in the past, or "N" for never experienced

C	P	N	Fatigue	C	P	N	Tremors	C	P	N	Head Trauma
C	P	N	Insomnia	C	P	N	Chronic Cough	C	P	N	Concussion
C	P	N	Snoring	C	P	N	Short of Breath	C	P	N	Seizures
C	P	N	Headaches	C	P	N	Painful Breathing	C	P	N	Nervousness
C	P	N	Dizziness	C	P	N	Difficulty Breathing	C	P	N	Anxiety
C	P	N	Vertigo	C	P	N	Asthma	C	P	N	Depression
C	P	N	Blurry Vision	C	P	N	Emphysema / COPD	C	P	N	Excessive Stress
C	P	N	Sinus Pain	C	P	N	Tuberculosis	C	P	N	Mood Swings
C	P	N	Congestion	C	P	N	Chest Pain	C	P	N	Schizophrenia
C	P	N	Neck Pain	C	P	N	Heart Disease	C	P	N	Bipolar Disorder
C	P	N	Mid-Back Pain	C	P	N	Heart Attack	C	P	N	Tourette's Syndrome
C	P	N	Low Back Pain	C	P	N	High Blood Pressure	C	P	N	Profuse Sweating
C	P	N	Pelvic / Hip Pain	C	P	N	High Cholesterol	C	P	N	Excessive Thirst
C	P	N	Arm / Hand Pain	C	P	N	Calf Pain w/ Walking	C	P	N	Diabetes
C	P	N	Leg / Foot Pain	C	P	N	GERD	C	P	N	Kidney Dysfunction
C	P	N	Loss of Motion	C	P	N	Heartburn	C	P	N	Kidney Failure
C	P	N	Scoliosis	C	P	N	Nausea	C	P	N	Excess Weight Gain
C	P	N	Swollen / Painful Joints	C	P	N	Constipation	C	P	N	Excess Weight Loss
C	P	N	Numbness / Tingling	C	P	N	Diarrhea	C	P	N	Cancer
C	P	N	Hives	C	P	N	Hemorrhoids	C	P	N	Stroke / TIA
C	P	N	Eczema / Psoriasis	C	P	N	Pain with Urination	C	P	N	Chronic Infection
C	P	N	Allergies/Anaphylaxis	C	P	N	Trouble Urinating	C	P	N	Arthritis, Rheumatoid
C	P	N	MRSA	C	P	N	Frequent Urination	C	P	N	Arthritis, Osteo
C	P	N	Tinnitus	C	P	N	Hernia	C	P	N	Hepatitis A / B / C
C	P	N	Hearing Loss	C	P	N	STD (gonorrhea, etc.)	C	P	N	HIV / AIDS
C	P	N	Fainting	C	P	N	Erectile Dysfunction	C	P	N	ADD / ADHD
C	P	N	Loss of Balance	C	P	N	Itching / Rashes	C	P	N	Learning Disability
C	P	N	Weakness	C	P	N	Heavy Menses	C	P	N	_____

Daily Activities, Functioning, and Movement

Please mark <u>ONLY the TOP 1 to 3</u> restrictions your condition is currently causing
if you CANNOT perform the activity at all, circle the word "not"; if you can perform activities WITHOUT pain, leave it blank

bending at the waist	can (not) perform _____ min / hrs	push / pull movements	can (not) perform _____ min / hrs
carrying groceries	can (not) perform _____ min / hrs	reading / concentration	can (not) perform _____ min / hrs
climbing stairs	can (not) perform _____ min / hrs	recreation	can (not) perform _____ min / hrs
cooking	can (not) perform _____ min / hrs	sexual activity	can (not) perform _____ min / hrs
crouching	can (not) perform _____ min / hrs	shaving	can (not) perform _____ min / hrs
descending stairs	can (not) perform _____ min / hrs	sitting to standing	can (not) perform _____ min / hrs
dressing	can (not) perform _____ min / hrs	sleeping	can (not) perform _____ min / hrs
driving	can (not) perform _____ min / hrs	standing to sitting	can (not) perform _____ min / hrs
eating	can (not) perform _____ min / hrs	static sitting / standing	can (not) perform _____ min / hrs
exercise / sports	can (not) perform _____ min / hrs	stooping	can (not) perform _____ min / hrs
extended computer use	can (not) perform _____ min / hrs	toilet use & hygiene	can (not) perform _____ min / hrs
getting in / out of bed	can (not) perform _____ min / hrs	turning / bending the head	can (not) perform _____ min / hrs
grasp / hold items	can (not) perform _____ min / hrs	twist / lean at the waist	can (not) perform _____ min / hrs
grooming	can (not) perform _____ min / hrs	using arms outstretched	can (not) perform _____ min / hrs
hobbies	can (not) perform _____ min / hrs	using arms overhead	can (not) perform _____ min / hrs
housework	can (not) perform _____ min / hrs	walking	can (not) perform _____ min / hrs
kneeling	can (not) perform _____ min / hrs	washing / bathing	can (not) perform _____ min / hrs
lifting items	can (not) perform _____ min / hrs	work duties	can (not) perform _____ min / hrs
looking up / down	can (not) perform _____ min / hrs	yardwork	can (not) perform _____ min / hrs

Patient Name: Date: File #:

Past Medical / Family / Social History

Surgery *Do you have a pacemaker - ❑ Yes ❑ No*

Date	Procedure Performed	
____/ ____/ ____	_____	_____
____/ ____/ ____	_____	_____
____/ ____/ ____	_____	

Medication(s) *(if a list is available, please provide it to us)*

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injury / Trauma

Date	Describe the Event
____/ ____/ ____	_____
____/ ____/ ____	_____
____/ ____/ ____	_____

Medication Allergy

Name	Reaction(s)
_____	_____
_____	_____
_____	_____

Serious Illness

Date	Illness
____/ ____/ ____	_____
____/ ____/ ____	_____
____/ ____/ ____	_____

Infectious Diseases

Date	Disease
____/ ____/ ____	_____
____/ ____/ ____	_____
____/ ____/ ____	_____

If you have any further information regarding medication, surgery, injury or illness listed above, please use the back of this page.

Family History *Does a family member have or had any of the conditions listed below*

(P) = Paternal or Father's Side of the Family, (M) = Maternal or Mother's Side of the Family

Grandfather (P)	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Grandfather (M)	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Grandmother (P)	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Grandmother (M)	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Father	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Mother	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Sister	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Brother	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder
Children	❑ Heart Disease	❑ Diabetes	❑ Cancer	❑ Stroke	❑ Arthritis	❑ Mental Disorder

Social History

Smoking:	❑ Daily (____ Packs per day)	❑ Occasional	❑ Quit Date ____/____/____	❑ Never	❑ Pipe	❑ Cigars	
Tobacco:	❑ Daily (____ Chew per day)	❑ Occasional	❑ Quit Date ____/____/____	❑ Never			
Alcohol:	❑ Beer	❑ Wine	❑ Liquor	❑ Daily	❑ Weekends	❑ Socially	❑ Occasionally	❑ Never
Exercise:	❑ Daily	❑ 3-4 times/week	❑ 1-2 times/week	❑ < 1 time/week	❑ Occasional	❑ None	
Diet:	❑ Balanced	❑ ↑ ↓ Fat	❑ ↑ ↓ Sugar	❑ ↑ ↓ Salt	❑ Unbalanced	❑ Vegetarian	
Work:	❑ Enjoyable	❑ Stressful	❑ Sedentary	❑ Active	❑ Blue-Collar	❑ White-Collar	
Work:	❑ Standing A Lot	❑ Walking A Lot	❑ Sitting A Lot	❑ Overhead Work	❑ Bend / Twist / Lift		
Sleep:	❑ >8 hours/night	❑ 7-8 hours/night	❑ 6-7 hours/night	❑ <6 hours/night	❑ Apnea		
Sleep:	❑ Unbroken	❑ Up 1-2 times/night	❑ Up several times/night	❑ Wake up to urinate frequently			

Have you ever been addicted to any illegal drug(s)? ❑ No ❑ Yes - which one(s):

Health Goals

What would you like to see accomplished with your care in our office? (You may choose more than one answer)

❑ Get out of pain ❑ Increase strength / flexibility ❑ Be more active at home ❑ Work more effectively
❑ Improve my diet ❑ Sleep more soundly ❑ Obtain more health ❑ Maintain my health

OTHER:

Patient Name: Date: File #:

Informed Consent for Chiropractic Treatment

In accordance with the ORC (Ohio Revised Code), section 4734.15 "scope of practice of chiropractic - permissible titles."

Analysis / Examination / Treatment

As a part of my full analysis of your presenting problem(s), I will perform a comprehensive history in order to assess your current presenting problem(s), as well as any past problem(s), past medical history (conditions, injuries, surgeries, medications, allergies and treatment), past family history and past / present social history. This will give me better insight pertaining to your presenting problem(s) and what may or may not have contributed to it. This also helps me to assess whether the treatment I provide will benefit you or not.

I will also perform a full examination on you after I have reviewed your history with you. The examination will include checking your posture, range of motion, reflexes, skin sensation (if warranted), muscle strength, and appropriate orthopedic testing. Dependant on my findings, I may order X-rays.

X-rays (Roentgen Rays)

A chiropractor may use x-rays in order to determine many things, including but not limited to: posture, spinal curvature / scoliosis, disc and joint integrity, disc or joint disease / degeneration, fracture, pathology, etc. If a film contains findings that I am not sure of, I will send them to a chiropractic radiologist, also known as a DACBR (Diplomate of the American Chiropractic Board of Radiology) for further assessment to ensure all questionable findings are addressed appropriately. I currently do not have x-ray equipment in my office, however, if this assessment is required, I will refer you to the appropriate facility for said studies. If you have past x-rays or MRI's that are within 2-3 years of your visit, please bring them upon your next visit so that I may review them. If I determine there are no contraindications, I will begin treatment.

The Nature of the Chiropractic Adjustment

The primary treatment used by doctors of chiropractic is the adjustment, or what is termed "spinal manipulative therapy." I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move the joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles, as well as a sense of movement in the joint.

The Material Risks Inherent in the Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck (i.e. "dissection") leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment (this is normal). The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor before treatment begins.

The Probability of those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke and / or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote (i.e. 1 in 5 million PLUS). Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include*: self-administered over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; hospitalization; surgery*. If you choose to use one of the above noted treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Also be aware that some of the risks are much greater than the risks associated with chiropractic care. Please note that I am a chiropractor and not a medical doctor, therefore, I do not dispense, prescribe or recommend medication, nor do I treat for infectious, contagious or venereal diseases or perform any type of surgical procedure. If this is the avenue you wish to pursue, please speak to your medical doctor for these recommendations.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over extended periods of time, this process may lead to tissue contracture and disc / joint degeneration. This process may complicate treatment, making it more difficult and less effective the longer treatment is postponed.

I certify that I have read the above information and understand its contents, having asked the Doctor any questions concerning its content. Therefore, I consent to chiropractic treatment and give Emerson Taylor, D.C., D.I.B.C.N. permission and authority to care for me in accordance with the chiropractic tests, diagnosis, and analysis mentioned above, according to his recommendations. I understand that the chiropractic doctor provides a specialized, non-duplicating health care service, is licensed in a special practice and is available to work with other types of providers in your health care regimen. I intend this consent to apply to all my present and future chiropractic care received in this office.

Patient Name: _____ Patient Signature: _____ Date: _____

Witness Name: ***Emerson S. Taylor, D.C., D.I.B.C.N.*** Witness Signature: _____ Date: _____

Batavia Chiropractic L.L.C. • 25 North Market Street • Batavia • OH • 45103 • P: (513) 515-4937 • F: (844) 692-7290

Patient Health Information (PHI) Informed Consent

Batavia Chiropractic, LLC wants you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the **HIPAA Notice** that is available to you at the front desk before signing this consent.

1.) The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2.) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions in certain circumstances.

3.) A patient's written consent need only be obtained one time for all subsequent care rendered to the patient in this office.

4.) The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care gvien after the request has been presented.

5.) For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in the office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6.) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures, and must be presented in writing.

7.) If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the Doctor of Chiropractic (Emerson S. Taylor, D.C., D.I.B.C.N.) reserves the right to refuse or deny any and all care to be rendered to the patient.

Missed Appointments:

If an appointment needs to be cancelled or rescheduled, we kindly ask for 24 hours notice prior to the scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No One: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

May we contact you via email? Yes [ ] No [ ]

Patient Name: _____ Patient Signature: _____ Date: _____

Witness Name: ***Emerson S. Taylor, D.C., D.I.B.C.N.*** Witness Signature: _____ Date: _____

Additional Information Sheet

Patient Name: Date: File #: