Natural Inner Health™
Stoneham, MA

CHIROPRACTIC HEALTH QUESTIONNAIRE

Name: _____

What do you prefer to be called? _____

Address:_____

_____

City:_____State_____ Zip code:_____

Home Phone: _____Work Phone:_____

Birth date: _____/_____/_____ Age: _____ Social Security #:_____

How did you learn about our office?

_____

Where is your personal health on your priority list 1-10: (1 being lowest, 10 being highest)

Do you believe your body has the power to heal itself? : _____ Yes_____No

How important is that for you? 1-10: (1 being lowest, 10 being highest)

_____

What are your expectations of care at Atlantic Chiropractic:_____

_____

Marital Status: _____Single _____Married _____Divorced _____ Separated _____Widowed

Spouse's Name: _____

Names and Ages of Children:_____

Hobbies: _____

Email: _____

Patient's Employer/Business: _____

Occupation: _____

Spinal health is very important during pregnancy. Is there any chance that you are pregnant?
___Yes ___No

Name of Health Insurance Company:

_____

_____

Terms Of Acceptance:

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same health objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion/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 adjustment of the spine.

Health: a state of optimal physical, mental and social well being and not merely the absence of disease or 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 innate 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 spinal examination, we encounter non-chiropractic or unusual finfins, we will recommend that you seek the services of a healthcare provider who specialized 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 subluxation.

I hereby authorize Atlantic Chiropractic to provide any and all forms, evaluations, x-rays and care that may be indicated in connection with the patient above, and further authorize and consent that Atlantic Chiropractic choose and employ such assistance as it sees fit. I also understand that prior to care; full explanation of procedure(s) involved will be given. I agree to pay for all services rendered in this office.

Signature: _____

Date: _____/_____/_____

Relationship to patient _____

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PATIENT HISTORY

Please Fill In The Appropriate Spaces (All information you give is confidential.)

NAME: _____DATE: _____/_____/_____

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset? _____/_____/_____

Have you lost workdays? ____ YES ____ NO If yes, how many? _____

Have you had this similar condition before? ____YES ____NO If yes, when? _____

Was the injury accident related? YES NO Auto Accident ____Work Accident If yes, when?

_____

When was your last auto accident? _____/_____/_____ When was the one before that? _____/_____/_____

Previous Chiropractic Care? ____YES ____NO Chiropractor's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

_____

Did you follow it? ____ YES ____NO If not, why? _____

Why are you changing Chiropractors? _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription). _____

_____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Please mark if you have had any of these symptoms or conditions in the last 12 months: Circle R (right) or L (left) as appropriate

- ❑ Fractured bones
- ❑ Auto Accidents
  - ____ 0-1 years ago
  - ____ 1-5 years ago
  - ____ 5 years or more
- ❑ Other accidents, falls
- ❑ Arthritis
- ❑ Diabetes
- ❑ Convulsions, epilepsy
- ❑ Skin problems
- ❑ Cancer
- ❑ Frequent colds, flu
- ❑ Depressed
- ❑ Irritable
- ❑ Anemia
- ❑ Allergy, sinus
- ❑ Under stress
- ❑ Eating disorders
- ❑ Trouble sleeping
- ❑ Trouble concentratin
- ❑ Learning disability
- ❑ Mood changes
- ❑ Neck pain or stiffness R L
- ❑ Numbness, tingling, pain in arms, hands, fingers R L
- ❑ Jaw pain or click (TMJ) R L
- ❑ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
- ❑ Shoulder pain R L
- ❑ Dizziness
- ❑ Ringing in ears R L
- ❑ Hearing Loss
- ❑ Blurred or double vision
- ❑ Upper back pain, stiffness
- ❑ Mid back pain, stiffness
- ❑ Lower back pain / stiffness
- ❑ Pain with cough, sneeze
- ❑ Hip pain R L
- ❑ Headaches
- ❑ Numbness, tingling, pain in buttocks, legs, feet, toes R L
- ❑ Foot trouble R L
- ❑ Chest Pain, asthma
- ❑ Heart problems
- ❑ Stroke
- ❑ High / low blood pressure
- ❑ Varicose veins
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Digestive problems
- ❑ Ulcers
- ❑ Hemorrhcids
- ❑ Prostate problems
- ❑ Impotence
- ❑ Kidney trouble
- ❑ Menstrual problems, PMS
- ❑ Pregnant (now)
- ❑ Bedwetting
- ❑ Ear infections
- ❑ AIDS, HIV

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HEALTH INSURANCE QUESTIONNAIRE

Please Check **One** of the Following:

( ) A. **I am** covered by my own **health** policy.
( ) B. **I am** covered by **someone else's health** policy (spouse, parent, guardian, dependent)
( ) C. **I am** not covered by any **health** policy.

(If A or B apply, please state the name of the health insurance company, insured's name and identification/group number)

Health Insurance Company:

Name: _____

Insured's Name: _____

Identification/Group #: _____

Date: _____/_____/_____ Signature: _____

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ASSIGNMENT OF BENEFITS

Date: _____/_____/_____

Patient's Name: _____

Atty. / Insurance Carrier: _____

I hereby authorize and direct Atlantic Chiropractic to release all medical information necessary to process this claim.

Date: _____/_____/_____ Patient's Signature: _____

I hereby authorize and direct my Atty. / Insurance Carrier to pay all benefits, which may be due to me according to my policy, directly to Atlantic Chiropractic to be applied toward my account.

Date: _____/_____/_____ Patient's Signature: _____

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DOCTOR'S LIEN

Patient's Name: _____

Claim No: _____

Atty. / Insurance Carrier: _____

I hereby authorize Atlantic Chiropractic to furnish you, my Attorney/Insurance Carrier, with a full report of his/her case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident / illness which occurred / began on _____.

I hereby give a lien to Atlantic Chiropractic on any settlement, claim, judgment or verdict as a result of said accident / illness and authorize and direct you, my attorney / Insurance Carrier, to pay directly to Atlantic Chiropractic such sums as may be due and owing him / her for services rendered to me and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect Atlantic Chiropractic adequately.

I fully understand that I am directly and fully responsible to Atlantic Chiropractic for all bills submitted by it Atlantic Chiropractic for services rendered to me and that this agreement is made solely for Atlantic Chiropractic's additional protection and in consideration of it's awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Date: _____/_____/_____ Patient's Signature: _____

The undersigned, being Attorney of record for the above patient, do hereby acknowledge receipt of the above lien and do agree to honor the same to protect Atlantic Chiropractic adequately.

Date: _____/_____/_____ Attorney's Signature: _____

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TERMS OF ACCEPTANCE

The practice of chiropractic in this office consists of:

1. Analysis for the purpose of locating vertebral subluxation (spinal misalignments causing nerve interference.)

2. Adjustment of the spine for the purpose of correcting vertebral subluxation.

3. Education and encouragement of our patients/practice members to become aware of and responsible for their well-being.

4. Empowerment of our patients/practice members as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I understand and wish to receive care at Atlantic Chiropractic for myself/my family, as outlined in this "Terms of Acceptance."

Signed: _____

Nane (Please Print): _____

Witness: _____

Date: _____/_____/_____

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CONSENT TO THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I, _____, hereby consent to the use or disclosure of my
Patient / Legal Guardian

Protected Health information by **Atlantic Chiropractic,** to carry out treatment, payment or other healthcare operations. I acknowledge receipt of a copy of rights extended to me and the ability to limit disclosure / use.

I understand and agree that **Atlantic Chiropractic** may use information about my medical issues / financial / insurance matters for my own treatment, payment for services rendered to me, or healthcare operations. I also assent to and understand that **Atlantic Chiropractic,** may use / disclose information to another healthcare provider for payment activities or for ongoing treatment, for review by the Department of Health and Human Services, other Government Agency, as permitted by law, for fraud and abuse detection or compliance, for quality assurance, utilization review purposes, for review of the competency and performance of practitioners, practitioner credentialing and training and education of any staff/students of **Atlantic Chiropractic**.

I understand that **Atlantic Chiropractic** retains the right to amend or change the terms of the Notice of its Privacy Practices at any time. I understand that I may obtain a copy of the Notice, at any time by requesting the same in writing to **Atlantic Chiropractic** at its office.

I understand and agree that I may revoke this consent at any time by writing to **Atlantic Chiropractic.** I understand and agree that the revocation shall be effective but for the extent that **Atlantic Chiropractic,** has already acted on same, or acted in reliance upon my previous consent.

I understand and agree that as the patient / legal guardian, the law affords me the right to seek a restriction of the use of protected health information. I also understand that **Atlantic Chiropractic** is not mandated to agree to said restriction. If I seek such a restriction on the use and disclosure of my protected health information, I must do so in writing to **Atlantic Chiropractic.** I understand that if **Atlantic Chiropractic** agrees to my requested restriction he must adhere to it, unless I am informed that **Atlantic Chiropractic** is terminating said agreement.

I further understand that **Atlantic Chiropractic** may refuse to treat me if I do not sign this Consent form, or revoke said Consent at any time (except if treatment is for an emergency condition at the actual time of treatment).

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Authorization for the Release of protected Health Information to Atlantic Chiropractic

I, _____, authorize _____to release / disclose
Patient/Legal Guardian provider to release info

Information concerning:

_____
(Describe information that you want released to Atlantic Chiropractic)

Atlantic Chiropractic may use the released protected health information until my condition subsides, until it is no longer clinically necessary, or until it is not longer required to fulfill "healthcare operations." or other activities permitted under HIPAA, the Federal law on Privacy

I understand that I might revoke this authorization at any time, except if it was used as a condition to obtaining insurance coverage for my treatment. I also understand that any revocation must be in writing and that said revocation will not be valid against releases/disclosures made prior to any revocation. I understand that said revocation will be effective immediately, but not if the provider has already acted on the same.
I understand that information disclosed might be redisclosed, and that said redisclosure might not be protected.

I acknowledge that I have read this Authorization and that I have authority to sign, that is, that I am a competent, individual, over the age of eighteen, or am the parent or legal guardian of the patient.

_____ _____/_____/_____
Patient / Legal Guardian Date

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NOTICE TO PATIENTS REGARDING YOUR PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is our Policy to conform to the New Federal Privacy Law, known as the Health Insurance Portability and Accountability Act. This law affords our patients very real rights. It is the intent of this Notice to advise patients of those rights and to encourage dialogue if you have questions after reviewing this Notice.

The laws require that our office maintain the privacy and confidentiality of your health information. Furthermore, the law requires us to provide this Notice to you outlining our privacy practices and legal duties. The law requires that we abide by the terms of this Notice.

1. The Provider may, from time to time, contact you via the telephone to remind you of an appointment, or to inform you of treatment alternatives, or other healthcare benefits and services that might be of interest to you. If you are not home, it is likely that the office staff will leave a message, if you have an answering machine, or voice mail.
2. The new Federal Privacy Law permits our office to forward medical records information on your treatment to other entities, without your express permission for routine matters such as further treatment outside of this office, to secure payment for services provided to you, and for other healthcare operations. The law requires us to provide some examples of what could be disclosed without your express authorization.
    a) If this office received a request from another medical provider treating you, this office would likely remit particular information to assist with your ongoing treatment.
    b) In order to secure payment, this office might remit copies of notes generated by the provider during your treatment. This information could include diagnostic and treatment information that will be “codified” and forwarded to an insurance company for payment.
    c) Sometimes, an insurance company denies payment for treatment and requests that the provider give the insurer a detailed summary as to why the treatment was necessary. In order to secure payment, this office could complete such a report and disclose information about your treatment.
    d) As part of our quality assessment and compliance programs, this office periodically reviews its treatment and bills to ensure that it is complying with other laws that govern healthcare. At times, this practice might engage an attorney or other external consultant to compare records and bills to ensure that our billing is accurate.
    e) The Department of Health and Human Services, Department of Public Health, or other health oversight agency, with the express authority under law, investigates and completes a compliance review of the office and requests to review patient’s records.

3. Except for the above types of routine disclosures, other uses or disclosures of your protected health information will be made only with your written authorization. If you ever complete such an authorization, this Notice advises you that you may decide to revoke the authorization at any time, so long as action has not already been taken in reliance upon the authorization, or if authorization was obtained as a condition of obtaining insurance coverage.
4. You have a right to request that restrictions be placed on the information routinely forwarded to other entities. To do so, you would need to forward a letter to this office, expressly stating what information you did not want released, and any type of information you did not want to be disclosed and to whom you do not want information disclosed. Please understand that the law states that the practice does not need to agree to such a restriction. Please understand that in the event of a medical emergency, even if this office has a restriction prohibiting further release of health information, the practice reserves its right to forward necessary medical information to the treating facility. In the event that this release occurs, we will make a good faith effort to convey to the facility not to further disclose this information. In fairness, we reserve the right to discuss payment with you at the time you make such a request, if you decide to restrict information flow to your insurance company. If you request that information to not be sent to your insurer, the practice reserves its right to obtain payment directly through you.
5. You have the right to request that we forward information to you at a different place, or at a different telephone, or by another means of communication. If you submit a request in writing to this office, asking that we contact you at a location different than your residence, or if you ask that we forward copies of medical records to a different location, our practice will make a good faith effort to accommodate your request.
6. Pursuant to Massachusetts law and the Federal Privacy law, you have the right to request a copy of your medical record. Upon receipt of a signed request from you, (or your legal guardian if you are a minor) we will consider the request and, if proper, permit the access to the information that our practice has determined to be the content of your "designated records set" (a term that includes many of the forms, notes and reports in your medical record folder.)
7. The Federal Privacy law grants you the right to find out if your health information has been released to anyone outside of those depicted in this Notice, or to someone else, without your authorization. In order to obtain such a report, you are asked to submit a request in writing to the practice. The request should ask for no more than six years of information. The provider is not mandated to release any information dated prior to April 14, 2003, the date the law went into effect. Furthermore, the provider reserves the right to charge a cost-based fee for the second request for such information within any 12-month period.
8. We intend to post this Notice in the Waiting Room and also to provide a copy to each patient at the very first appointment. If at any time, you desire an additional copy of this Notice, all you need to do is ask the receptionist to provide you with a copy at your next visit, or call the office and ask that a copy of the Notice be mailed to you.
9. If you believe that your privacy rights have been violated, you have a right to file a complaint with this office. To do so, you need to forward a written letter to the Privacy Office of Atlantic Chiropractic. Additionally, you may file a complaint with the Secretary of the Department of Health and Human Services. If you file a complaint, either with our office or the DHHS, you will not be retaliated against by this practice, its employees, owners, or agents.
   We Reserve the Right to change this Notice or Privacy Policy and to make any new Notice effective for all health information retained by this office. If the Notice is revised, the revised Notice will be posted in a prominent location in the Patient's Waiting Room

   The Effective Date of this Notice is: _____