INTEGRATIVE
HEALTHCARE CENTER

PATIENT INFORMATION

Date: _____

Name:_____ Nickname: _____

Street Address:_____

City: _____ State: _____ Zip: _____

Female:_____ Male:_____ Age:_____ Birth date:_____

Single:____ Married:_____ Spouse's name: _____

SSN: _____ - _____- _____

Employer:_____

Employer's Address:_____

Occupation: _____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home: _____-____-_____ Cell: _____-____-_____Cell Phone Carrier_____

Contact Preference: □ Home □ Work □ Cell

E-Mail Address:_____
(will not be shared)

INSURANCE

Cardholder's Name:

_____ Relationship to Patient: _____

Birth date: ____-____-_____ SSN: _____-____-_____

Assignment and Release

I understand that I am financially responsible for all charges whether paid or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of the signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

For office use only

____ Insurance Verification	___ Xray sent	___ Thank you
____ Eclipse # _____	___ Fax sent	___ Referral
____ CP	___ DRIP	

Reason for visit: _____

_____

_____

Please check conditions or symptoms you currently have or have had in the past:

__AIDS/HIV	__Chemical Dependency	__Herpes	__Pinched Nerve
__Anemia	__Diabetes	__High Blood Pressure	__Pneumonia
__Appendicitis	__Emphysema	__High Cholesterol	__Polio
__Arthritis	__Goiter	__Jaw Pain/TMJ	__Prosthesis
__Asthma	__Gout	__Kidney Disease	__Psychiatric Care
__Blood Clots	__Heart Disease	__Liver Disease	__Rheumatoid Arthritis
__Breast Lump	__Hepatitis	__Multiple Sclerosis	__Stroke
__Bronchitis	__Hernia	__Osteoporosis	__Thyroid Problems
__Cancer	__Herniated Disk	__Pacemaker	__Tuberculosis

Routine physical exercise: Type of exercise:

_____

Minutes per day:_____ Times per week: _____

Dietary preferences/restrictions:

_____

_____

TOBACCO	**AMOUNT**	**CAFFEINE**	**AMOUNT**	**ALCOHOL**	**AMOUNT**
__Current/Pks per day	_____	__Coffee	_____	__Wine	_____
__Previous/Pks per day	_____	__Tea	_____	__Beer	_____
How long has it been		__Soda	_____	__Hard Liquor	_____
since you quit?_____		__Chocolate	_____		

Are there health hazards that you are exposed to at home/work, such as toxic chemicals, dust, fumes, etc?
__Yes __No If yes, describe:

_____

Do you suffer from any form of arthritis? ___Yes ___No Location_____
Do you suffer from headaches? __Yes __No How often? _____
Do you have persistent stomach pain, indigestion, or trouble with bowel movements, such as constipation or diarrhea?
__Yes __No If yes, describe _____
Do you suffer from specific symptoms of ill health, such as:
Irritability .....__Yes __No
Difficulty in concentrating .....__Yes __No
Mood Swings.....__Yes __No
Dizziness, trembling, palpitations.....__Yes __No
Brain fog/loss of mental acuity.....__Yes __No
Concerns about your present weight.....__Yes __No
Anxiety, sadness, and depression for which there is no situational explanation __Yes __No
Inexplicable drops in your strength stamina at various times throughout the day __Yes __No
Is your stress level __Low __Medium __High

WOMEN ONLY
Are you pregnant? __Yes __No
Date of last menstrual cycle?_____
Are you experiencing any female related complaints at this time? __Yes __No

Explain:_____

_____

Have you experienced any problems in the past? __Yes __No

Explain:_____

_____

How many pregnancies?_____ How many births?_____
Did you have any difficulties or complications during pregnancy or delivery?_____

Medical History

Name: _____ Date: _____

Do you experience any of the following symptoms?
Please rate each of the following symptoms based upon your typical day.

4= frequently have it, effect is severe
3= frequently have it, effect is not severe
2= occasionally have it, effect is severe
1= occasionally have it, effect is not severe
0= never or almost never have the symptom

1. Digestive
___ Constipation
___ Diarrhea or loose stool
___ Gas
___ Belching
___ Bloating
___ Poor Digestion
___ Abdominal Pain
___ Heartburn
___ Indigestion
___ Bad Breath

2. **Head, emotions and mind**
___ Headaches
___ Depression
___ Anxiety
___ Fear
___ Nervousness
___ Irritable or anger easily
___ Become aggressive easily
___ "Fly off the handle"
___ Reduced memory
___ Reduced concentration
___ Head pressure
___ Difficulty thinking clearly
___ Mood Swings
___ Difficulty in making decisions
___ Confusion
___ Poor comprehension
___ Learning difficulties
___ Hyperactivity
___ Restlessness
___ Insomnia
___ Drowsiness
___ Have seen a psychologist

3. Energy activity
___ Tire easily/fatigue/low level of energy
___ Wake up tired
___ Tired by the end of the day
___ Sleep excessively
___ Feel excessively cold
___ Weight gain

4. Skin
___ Feel excessively cold
___ Cold hands
___ Cold feet
___ Dry skin
___ Acne
___ Rashes

5. Muscles/Joints
___ Muscle aches/muscle pain/muscle spasms; Where (circle all that apply) forearms, fingers, thighs, legs/feet, neck generalized
___ Muscle cramps/charley horses
___ Low back pain/spasms
___ Pain/tightness in upper back
___ Pain tightness in neck/shoulder area
___ Joint pains, Where; (circle all that apply) shoulders, elbows, wrists, hands, hips, knees ankles foot, multiple joints.

6. Cardiovascular
___ High blood pressure
___ Rapid heartbeat/irregular heart beat
___ Have seen a cardiologist
___ Palpitations

7. Nose
___ Stuffy nose
___ Runny nose
___ Hay fever
___ Sniffles
___ Sneezing attacks
___ Postnasal drip
___ Sinus infections

8. Lungs
___ Wheezing
___ Asthma
___ Difficulty in breathing
___ Chest tightness
___ Chest congestion
___ Shortness of breath
___ Chronic cough

9. Urinary tract
___ Frequent urination
___ Burning on urination
___ Wake at night to urinate

10. For women only:
Female Reproductive System
___ Have ever had vaginal yeast infection? If yes, total number of times in your lifetime. _____
___ Vaginal discharge
___ Premenstrual symptoms, a few to several days before menstruation. If yes, what symptoms to you have?
___ Premenstrual Headaches
___ Premenstrual Depression
___ Premenstrual irritability
___ Premenstrual anxiety
___ Premenstrual bloating
___ Premenstrual fluid retention
___ Other symptoms
_____
_____

11. For both men and women: Have you ever been diagnosed with the following?
___ Hypothyroidism (Low thyroid)
___ Goiter (enlarged thyroid)
___ High cholesterol
___ High triglycerides
___ Diabetes
___ Hypoglycemia
___ Fibromyalgia
___ Mitral valve prolapse
___ Irritable bowel syndrome

11. Continued
___ Gallstones
___ Alcoholism
___ Drug abuse
___ Endometriosis (women)
___ Fibrocystic (women)

12. Do you smoke? ___yes ___no

13. Do any of the following bother you?
___ Tobacco smoke
___ Exhaust fumes
___ Bleaches
___ Detergents
___ Ammonia
___ Asphalt
___ Tar
___ Mothballs
___Insect sprays
___ Paints
___ Varnishes
___ Perfumes
___ Hair Sprays
___ Cosmetics
___ Gasoline products
___ Natural gas
___ Furniture polish
___ Floor wax
___ Newsprint
___ New fabric stores
___ Odors of any kind

14. Do foods bother you or disagree with you, including alcohol? ___ Yes ___ No
If yes, please explain:
_____
_____
_____

15. Do you crave or over-consume sugar, bread, chocolate, colas or alcohol? ___ Yes ___ No

16. Do you get sleepy, tired, have indigestion or any other symptoms after meals of after certain foods? If yes, please explain. ___ Yes ___ No
_____
_____
_____

17. Are you allergic to any medicines? ___ Yes ___ No

18. Effects of Illness:

- How many days out of the month are your "good days", i.e. when you feel perfectly fine and nothing seems to bother you? _____ days.
- How many days out of the month are your "bad days", i.e. when your symptoms bother you? ____ days

How are these symptoms bothersome for you? i.e. how are they interfering with your daily activities, family life or career?

_____

_____

_____

Have you seen a chiropractor before? **___ Yes _____ No**

What treatment have you already received for your condition?
Medication_____ Surgery _____ Physical Therapy_____
Chiropractic Services_____None_____

Name of Doctor(s) who have treated you for your condition:_____

Vitamins/Supplements taken regularly (and reason):

_____

_____

Surgeries: (Please list date and type)

_____

_____

Major Injuries: (Please list date and any treatments)

_____

_____

Medications taken regularly: (Include reason for taking)

_____

_____

_____

Consent to Chiropractic Services

Consent to Chiropractic Services

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays and / or other tests by Amy Horn, D.C. and her staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor and /or with office personnel the nature and purpose of treatment, including but not limited to fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read the above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures, I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and / or employed staff.

Signed_____ Date_____

Witness_____ Date_____

Consent to Treatment of a Minor

I have authority to & do authorize Amy Horn, D.C. to administer chiropractic care as deemed necessary to my:

(Relationship)_____

(Name)_____

Female Patients

I hereby certify that to the best of my knowledge, I am not pregnant and Dr. Amy Horn has my permission to take x-rays of me. Date of last menstrual cycle_____
Do you have implants of any kind? Yes___ No____

Financial Policy

1. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by the third party payers.

2. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy. The privilege of insurance assignment begins when our office receives your insurance forms. (Claim Forms, etc.)

3. All deductible/co-payments are payable when service is rendered or at the end of each week. A $200.00 co-payment balance must not be exceeded by any patient.

4. I understand that I am financially responsible for all charges whether paid or not paid by my insurance. Since we do not own your policy and occasionally we experience difficulty in collecting from you carrier, we may ask for your active assistance in rectifying this situation.

5. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

6. This office does submit to secondary insurance companies. If the secondary insurance company does not pay for the amount that the primary did not cover, then I understand that I am liable for those charges.

7. Returned checks and balances over 30 days will be subject to additional collections fees and interest charges. (Past due account will be sent to collections after 60 days). I understand that I am responsible for any charges and fees from the collections agency.

8. We require 24 hour notice to cancel an appointment. Any missed appointments without notice will result in a $10 fee.

9. If you have a personal injury case with us and it is not settled within 60 days of being released, you will be responsible to start payment towards this balance.

10. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

11. Xray Policy: Dr Horn's chiropractic technique requires that he views the patient's entire spine by xray. Insurance policies will only cover areas that are troublesome to the patient. Therefore, xrays unrelated to the diagnosis will be the patient's responsibility and payment will be due at the time of service.

I have read, understand & agree to the office and financial policies for Integrative Healthcare Center.

Signed_____ Date_____

Witness_____ Date_____

NOTICE OF PRIVACY PRACTICES:

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include exams and therapy.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written requests to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of ____1/1_____, 2016 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Service
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have read a copy of
(Please print)
this office's Notice of Privacy Practices.

_____
Signature

_____
Relationship to patient

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)