ELITE HEALTH & WELLNESS CENTERS

271 E. Helen Ave Palatine, IL. 60067

Chiropractic Medicine Division

General Information *(If more space is needed when filling in info, feel free to provide your own separate sheet.)*

Name: *First*_____ *Middle*_____ *Last*_____

Preferred Name:_____Social Security Number_____Date of Birth: ____/____/____

Age: _____ Gender: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed

Genetic Background: □ African □ Asian □ European □ Ashkenazi □ Native American

□ Middle Eastern □ Mediterranean □ Other _____

Primary Address: _____ Apt. No.: _____

City: _____ *State:* _____ *Zip:* _____

Home#:( ) _____ Work# ( )_____

Cell# ( ) _____ Carrier:_____

Preferred Method of contact (circle one): Home Work Cell Text Email

Email: _ _____

Emergency Contact: Name_____ Phone_____

Address: _____

City: _____ State: _____ Zip: _____

Highest Education Level: □ High School □ Graduate □ Post-Graduate

Job Title:_____ Nature of Business:_____

Whom may we thank for referring you?_____

Insurance Information

If we are in network and you would like us to submit your claim directly to your insurance company, please fill out info below. We will need a copy of your current insurance card. Please carefully read the additional insurance forms you will need to fill out separately from this intake.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with: *Name of Insurance Company(ies)* _____

_____ and assign directly to Dr. Leahy all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents. For the purpose of obtaining payment for services and determining insurance for the purpose of benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative _____

Please print name of Patient, Parent, Guardian, or Personal Representative _____

Date ____/____/____ *Relationship to Patient* _____

Payment Information

Payment is due at time of service, no exceptions. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement for a small setup and statement fee. Please see our insurance policy handouts for more information. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.

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Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

What do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

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Health Concerns & Goals

Health Concern or Goal #3 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

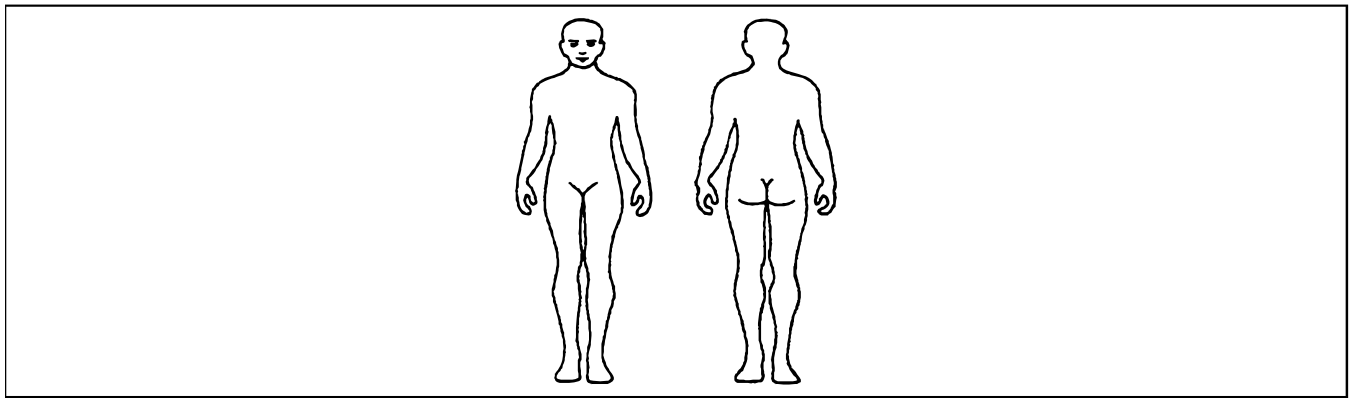
How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

_____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box.



Other comments you think are important _____

_____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

□ Doctor of Chiropractic *Name:* _____ *City:*_____

Treatment Focus: _____

□ M.D. / D.O. *Name:* _____ *City:*_____

Treatment Focus: _____

□ Physical Therapist *Name:* _____ *City:*_____

Treatment Focus: _____

□ Acupuncture *Name:* _____ *City:*_____

Treatment Focus: _____

□ *Other:* _____

Name: _____ *City:*_____

Treatment Focus: _____

Medical History *continued*

Hospitalizations □ None

*Date*_____ - *Reason* _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Allergies

Medication/Supplement/Food	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* □ *Past Condition* □ *Ongoing Condition*

Gastrointestinal
- □ □ Irritable Bowel Syndrome ___ /____
- □ □ Inflammatory Bowel Disease ___ /____
- □ □ Crohn's ___ /____
- □ □ Ulcerative Colitis ___ /____
- □ □ Gastritis or Peptic Ulcer Disease ___ /____
- □ □ GERD *(reflux)* ___ /____
- □ □ Celiac Disease ___ /____
- □ □ Hemorrhoids ___ /____
- □ □ Other ___ /____ _____

Cardiovascular
- □ □ Heart Attack ___ /____
- □ □ Other Heart Disease ___ /____
- □ □ Stroke ___ /____
- □ □ Elevated Cholesterol ___ /____
- □ □ Arrhythmia *(irregular heart rate)* ___ /____
- □ □ Hypertension *(high blood pressure)* ___ /____
- □ □ Rheumatic Fever ___ /____
- □ □ Mitral Valve Fever ___ /____
- □ □ Other ___ /____ _____

Cancer
- □ □ Lung Cancer ___ /____
- □ □ Breast Cancer ___ /____
- □ □ Colon Cancer ___ /____
- □ □ Ovarian Cancer ___ /____
- □ □ Prostate Cancer ___ /____
- □ □ Skin Cancer ___ /____
- □ □ Other ___ /____ _____

Genital & Urinary Systems
- □ □ Kidney Stones ___ /____
- □ □ Gout ___ /____
- □ □ Interstitial Cystitis ___ /____
- □ □ Frequent Urinary Tract Infections ___ /____
- □ □ Frequent Yeast Infections ___ /____
- □ □ Erectile or Sexual Dysfunctions ___ /____
- □ □ Other ___ /____ _____

Metabolic/Endocrine
- □ □ Type 1 Diabetes ___ /____
- □ □ Type 2 Diabetes ___ /____
- □ □ Hypoglycemia ___ /____
- □ □ Metabolic Syndrome *(Insulin Resistance/ Pre-Diabetes)*___ /____
- □ □ Hypothyroidism *(low thyroid)* ___ /____
- □ □ Hyperthyroidism *(overactive thyroid)* ___ /____
- □ □ Endocrine Problems ___ /____
- □ □ Polycystic Ovarian Syndrome *(PCOS)* ___ /____
- □ □ Infertility ___ /____
- □ □ Weight Gain ___ /____
- □ □ Weight Loss ___ /____
- □ □ Frequent Weight Fluctuations ___ /____
- □ □ Bulimia ___ /____
- □ □ Anorexia ___ /____
- □ □ Binge Eating Disorder ___ /____
- □ □ Night Eating Syndrome ___ /____
- □ □ Eating Disorder *(non-specific)* ___ /____
- □ □ Other ___ /____ _____

Musculoskeletal/Pain
- □ □ Osteoarthritis ___ /____
- □ □ Fibromyalgia ___ /____
- □ □ Chronic Pain ___ /____
- □ □ Tendonitis ___ /____
- □ □ Tension Headaches ___ /____
- □ □ TMJ Problems ___ /____
- □ □ Foot Cramps ___ /____
- □ □ Joint Deformity ___ /____
- □ □ Joint Pain ___ /____
- □ □ Other ___ /____ _____

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune
- □ □ Chronic Fatigue Syndrome ___ /____
- □ □ Autoimmune Disease ___ /____
- □ □ Rheumatoid Arthritis ___ /____
- □ □ Lupus SLE ___ /____
- □ □ Immune Deficiency Disease ___ /____
- □ □ Herpes-Genital ___ /____
- □ □ Cold Sores ___ /____
- □ □ Severe Infectious Disease ___ /____
- □ □ Poor Immune Function *(frequent infections* ___ /____
- □ □ Food Allergies ___ /____
- □ □ Environmental Allergies ___ /____
- □ □ Multiple Chemical Sensitivities ___ /____
- □ □ Latex Allergy ___ /____
- □ □ Other ___ /____ _____

Respiratory Diseases
- □ □ Asthma ___ /____
- □ □ Chronic Sinusitis ___ /____
- □ □ Bronchitis ___ /____
- □ □ Emphysema ___ /____
- □ □ Pneumonia ___ /____
- □ □ Tuberculosis ___ /____
- □ □ Sleep Apnea ___ /____
- □ □ Other ___ /____ _____

Head, Eyes, & Ears
- □ □ Conjunctivitis ___ /____
- □ □ Distorted Sense of Smell ___ /____
- □ □ Distorted Taste ___ /____
- □ □ Ear Fullness ___ /____
- □ □ Ear Pain ___ /____
- □ □ Hearing Loss ___ /____
- □ □ Hearing Problems ___ /____
- □ □ Headache ___ /____
- □ □ Migraine ___ /____
- □ □ Sensitivity to Loud Noises ___ /____
- □ □ Vision Problems *(other than glasses)* ___ /____
- □ □ Macular Degeneration ___ /____
- □ □ Vitreous Detachment ___ /____
- □ □ Retinal Detachment ___ /____
- □ □ Other ___ /____ _____

Nails
- □ □ Bitten ___ /____
- □ □ Brittle ___ /____
- □ □ Curve Up ___ /____
- □ □ Frayed ___ /____
- □ □ Fungus-Fingers ___ /____
- □ □ Fungus-Toes ___ /____
- □ □ Pitting ___ /____
- □ □ Ragged Cuticles ___ /____
- □ □ Ridges ___ /____
- □ □ Soft ___ /____
- □ □ Thickening of Finger Nails ___ /____
- □ □ Thickening of Toenails ___ /____
- □ □ White Spots/Lines ___ /____

Skin Diseases
- □ □ Acne on Back ___ /____
- □ □ Acne on Chest ___ /____
- □ □ Acne on Face ___ /____
- □ □ Acne on Shoulders ___ /____
- □ □ Athlete's Foot ___ /____
- □ □ Bumps on Back of Upper Arms ___ /____
- □ □ Cellulite ___ /____
- □ □ Dark Circles Under Eyes ___ /____
- □ □ Ears Get Red ___ /____
- □ □ Easy Bruising ___ /____
- □ □ Lack of Sweating ___ /____
- □ □ Hives ___ /____
- □ □ Jock Itch ___ /____
- □ □ Lackluster Skin ___ /____
- □ □ Moles w/ Color/Size Change ___ /____
- □ □ Oily Skin ___ /____
- □ □ Pale Skin ___ /____
- □ □ Patchy Dullness ___ /____
- □ □ Rash ___ /____
- □ □ Red Face ___ /____
- □ □ Sensitive to Bites ___ /____
- □ □ Sensitive to Poison Ivy/Oak ___ /____
- □ □ Shingles ___ /____
- □ □ Skin Darkening ___ /____
- □ □ Strong Body Odor ___ /____
- □ □ Hair Loss ___ /____
- □ □ Vitiligo ___ /____
- □ □ Eczema ___ /____
- □ □ Psoriasis ___ /____
- □ □ Melanoma ___ /____
- □ □ Skin Cancer ___ /____
- □ □ Other ___ /____ _____

Neurologic/Mood
- □ □ Depression ___ /____
- □ □ Anxiety ___ /____
- □ □ Bipolar Disorder ___ /____
- □ □ Schizophrenia ___ /____
- □ □ Headaches ___ /____
- □ □ Migraines ___ /____
- □ □ ADD/ADHD ___ /____
- □ □ Autism ___ /____
- □ □ Mild Cognitive Impairment ___ /____
- □ □ Memory Problems ___ /____
- □ □ Parkinson's Disease ___ /____
- □ □ Multiple Sclerosis ___ /____
- □ □ ALS ___ /____
- □ □ Seizures ___ /____
- □ □ Other Neurological Problems _____

Blood Type

□ A □ B □ AB □ O □ Rh+ □ unknown

Injuries

Check box if yes and provide date/description
- □ Back Injury ___ /____ _____
- □ Head Injury ___ /____ _____
- □ Neck Injury ___ /____ _____
- □ Broken Bones ___ /____ _

Diseases/Diagnosis/Conditions: *continued*

Female Repoductive

□ □ Breast Cysts ___ /____
□ □ Breast Lumps ___ /____
□ □ Breast Tenderness ___ /____
□ □ Ovarian Cysts ___ /____
□ □ Poor Libido ___ /____
□ □ Vaginal Discharge ___ /____
□ □ Vaginal Odor ___ /____
□ □ Vaginal Itch ___ /____
□ □ Vaginal Pain with Sex ___ /____
□ □ Other ___ /____ _____

Surgeries

Check box if yes and provide date of surgery

□ Appendectomy ___ /____
□ Hysterectomy +/- Ovaries ___ /____
□ Gall Bladder ___ /____
□ Hernia ___ /____
□ Tonsillectomy ___ /____
□ Dental Surgery ___ /____
□ Joint Replacement: Knee/Hip ___ /____
□ Heart Surgery: Bypass Valve ___ /____
□ Angioplasty or Stent ___ /____
□ Pacemaker ___ /____
□ Other ___ /____ _____
□ None

Male Reproductive

□ □ Discharge from penis ___ /____
□ □ Ejaculation Problem ___ /____
□ □ Genital Pain ___ /____
□ □ Impotence ___ /____
□ □ Prostate or Urinary Infection ___ /____
□ □ Lumps in Testicles ___ /____
□ □ Poor Libido *(Sex Drive)* ___ /____
□ □ Other ___ /____ _____

Preventive Tests

Check box if yes and provide date of most recent test

□ Blood Tests ___ /____
□ Full Physical Exam ___ /____
□ X-Ray ___ /____ *Body Part?*_____
□ Dental X-Ray ___ /____
□ Bone Density ___ /____
□ Colonoscopy ___ /____
□ Cardiac Stress Test ___ /____
□ EKG ___ /____
□ Hemoccult Test (stool test for blood) ___ /____
□ MRI ___ /____
□ CT Scan ___ /____
□ Upper Endoscopy ___ /____
□ Upper GI Series ___ /____
□ Ultrasound ___ /____
□ Other ___ /____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if yes and provide relevant quantity*

□ Pregnancy____ □ Vaginal Delivery____ □ Caesarean Delivery____ □ Miscarriage____ □ Abortion____
□ Living Children____ □ Post Partum Depression____ □ Toxemia____ □ Gestational Diabetes____
□ Baby over 8 lbs. ____ □ Premature____
□ Breast Feeding____ *How long?* _____ □ Oral Contraceptives____ *How long?* _____

Menstrual History

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has you period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No *If yes:* □ Condom □ Diaphragm □ IUD □ Partner Vasectomy

Women's Disorder/Hormonal Imbalances

□ Fibrocystic Breasts □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram: □ Breast Biopsy ___ /___ /____ □ Thermogram ___ /___ /____
Last PAP Test: □ Normal □ Abnormal
Date of Last Bone Density: ___ /___ /____ Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No Age of onset of menopause: _____

Check box if you are experiencing

□ Hot Flashes □ Mood Swings □ Concentration/Memory Problems □ Vaginal Dryness
□ Decreased Libido □ Heavy Bleeding □ Joint Pains □ Headaches □ Weight Gain
□ Loss of Control of Urine □ Palpitations
□ Use of hormone replacement therapy *How Long?* _____ *What hormones and dosage?* _____
_____

Men's History *(for men only)*

Have you had a PSA done? □ Yes □ No Date of last test? ___ /___ /____
Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10
Check box if you are experiencing
□ Prostate Enlargement □ Prostate Infection □ Change in Libido □ Impotence
□ Difficulty Obtaining an Erection □ Difficulty Maintaining an Erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____
□ Urgency/Hesitancy/Change in Urinary Stream □ Loss of Control of Urine

Medications

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications*: Last 10 Years*

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: *(Vitamins, Minerals, Herbs, &Homeopathy) If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No
Describe: _____
Have you had prolonged *(3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Aspirin, etc.)*? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No
For what reason, and for how long, did you use pain relievers? _____
How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____
Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? □ Yes □ No
Have you taken antibiotics **more than** 1 x per year? □ Yes □ No
Have you had long-term use of antibiotics? *(More than 10 days.)* □ Yes □ No
How many times have you taken antibiotics throughout your lifetime? _____

GI History

Foreign travel? □ Yes □ No *Where?* _____
Wilderness Camping □ Yes □ No *Where?* _____
Have you had severe: □ Gastroenteritis □ Diarrhea
Do you feel like you digest your food well? □ Yes □ No Do you feel bloated after meals? □ Yes □ No

Patient Birth History

□ Term □ Premature *Pregnancy Complications:* _____
Birth Complications: _____
□ Breast Fed *How long?* _____ □ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat candy or sugar as a child? □ Yes □ No

Dental History

Dental Surgery? _____
□ Silver Mercury Fillings *How many?* _____ □ Gold Fillings □ Root Canals □ Implants □ Tooth Pain
□ Bleeding Gums □ Gingivitis □ Problems with Chewing
Do you floss regularly? □ Yes □ No Do you brush regularly? □ Yes □ No
What toothpaste do you use? _____ Have you had Fluoride treatments? □ Yes □ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:* _____
_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches
Do you adversely react to: *Check all that apply*
□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*
□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion
□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Environmental & Detoxification Assessment

Which of these significantly affect you? *Check all that apply*

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____
In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold
How often do you use your cell phone? ____ $^{hrs}/_{day}$ How often do you use your computer? ____ $^{hrs}/_{day}$ ____ $^{hrs}/_{wk}$
Have you ever turned yellow *(jaundiced)*? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
If yes, explain _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides *(frequent visits of exterminator)* □ Pesticides □ Organic Solvents
□ Heavy Metals □ Other _____
Chemical *Name/Date/Length of Exposure (if known)* _____
Do you dry clean your clothes frequently? □ Yes □ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? □ Yes □ No
Do you have any pets or farm animals? □ Yes □ No
What detergents/soaps do you use *(Brand names)*? _____
What deodorant? _____

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Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age *(if still alive)*												
Age at Death *(if deceased)*												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Sondylitis)*												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases *(such as Lupus)*												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as Alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

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HIPAA AUTHORIZATIONS

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected information *(PHI).* The individual is also provided the right to request confidential communications or that a communication of *(PHI)* be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

____ Home Telephone _____ _____ Written Communication

____ O.K. to leave message with detailed information _____ O.K. to mail to my home

____ Leave message with call back number only _____ O.K. to mail to my office

_____ O.K. to fax to this number _____

____ Cell Telephone _____ Carrier_____

____ O.K. to leave message with detailed information _____ Other _____

____ Leave message with call back number only EMAIL: _____

____O.K. to send Text Messages regarding my appointments

_____ Work Telephone

_____ O.K. to leave message with detailed information

_____ Leave message with call back number only

_____ I acknowledge that I have received a copy/have read the notice of Privacy Practices of Elite Health and Wellness Center/Illinois Chiropractic Centers

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

AUTHORIZED PERSON(S) TO RECEIVE HEALTHCARE INFORMATION

_____

Elite Health&Wellness Centers .

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Patient Health Information Consent Form

We want 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 will begin any health care 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.
3. A patient's written consent need only be obtained one time for all subsequent care given 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 given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our 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.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date