

Dr. Daniel Hamlin, D.C.

St. Helena Chiropractic
999 Adams St. Suite 306
St. Helena, CA 94574
(707) 963-9433

Dr. Michael Cleaver, D.C.

1 PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ St. _____ Zip _____
E-mail _____
Driver's License # _____ State _____
Sex M F Height _____ Weight _____
Date of Birth _____ Age _____
 Single Married Divorced Minor
of Children _____ Spouse (or parent) _____
Employer/School _____
Occupation _____
Employer/School Address _____

Employer/School Phone (____) _____
Previous Chiropractic Care Yes No
If Yes, when? _____
Whom may we thank for referring you? _____

2 PHONE NUMBERS

Home Phone (____) _____ Cell (____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone _____ Work Phone _____

3 ACCIDENT INFORMATION

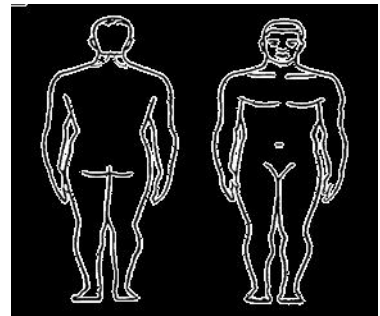
Is condition due to an accident? Yes No
No If Yes, Date _____
Type of Accident Auto Work Home Other
To Whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp.
 Other _____
Attorney Name (If applicable) _____

4 INSURANCE INFORMATION

Insurance Co. _____ Policyholder _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Phone # (____) _____
Subscriber ID _____ Subscriber Date of Birth _____ Group # _____

5 PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting worse? Yes No Unknown
Mark an X on the picture where you have pain, numbness, tingling.
Rate severity of your pain from 0 (no pain) to 10 (severe) _____
Type of pain: Sharp Aching Stabbing Burning Numbness
 Dull Throbbing Tingling Stiffness Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with Work Sleep Daily Routine Recreation
Activities that are painful to perform Sitting Standing Walking Bending Lying down



6

HEALTH HISTORY

What treatment have you already received? Medications Physical Therapy Chiropractic None Other _____

Name of other doctor(s) you have seen for this condition _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____

MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking _____ Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol _____ Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks _____ Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries / Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / MINERALS / HERBS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient / Guardian Signature: _____ Date: _____

Office Use Only
Patient / Parent / Guardian Photo Identification Verified

Signature **Date**

St. Helena Chiropractic
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St. Helena, CA 94574
Phone (707) 963-9433 Fax (707) 963-9423

Privacy Policy

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.

St. Helena Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with St. Helena Chiropractic.”

“It is our policy to provide a substitute health care provider, authorized by St. Helena Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event your primary health care provider’s absence due to vacation, sickness, or other emerging situation.”

Payment – We may disclose your health information to your insurance provider for the purpose of payment or health care operation. (Example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to St. Helena Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services rendered.”

Worker’s Compensation – We may disclose your health information as necessary to comply with State Worker’s Compensation Laws.

Emergencies – We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health – As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings – We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement – We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons – We may disclose your health information to coroners or medical examiners.

Organ Donation – We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research – We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety – It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies – We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing – We may contact you for marketing purposes as described below: (Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. We may also call to remind you of a missed appointment. If you are not at home, we may leave a reminder message on your answering machine or with the person answering the phone. No personal health

information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to contact you about many marketing events throughout the year. During these times we will be sending out various mailers, which include the internet. They may include your name thanking you for referrals. We may be asking you to share your Chiropractic success story with others. It is not our policy to disclose any health information about your condition for the purpose of personal gain without your permission.”

Change of Ownership – In the event that St. Helena Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised; however, that St. Helena Chiropractic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that St. Helena Chiropractic amend your protected health information. Please be advised; however, that St. Helena Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by St. Helena Chiropractic.
- You have the right to a paper copy of this Privacy Policy at any time upon request.

Changes to this Privacy Policy

St. Helena Chiropractic reserves the right to amend this Privacy Policy at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, St. Helena Chiropractic is required by law to comply with this policy.

St. Helena Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Daniel Hamlin, D.C. by calling this office at 707-963-9423. If Dr. Daniel Hamlin, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your privacy rights, or how St. Helena Chiropractic has handled your health information should be directed to Dr. Daniel Hamlin by calling this office at 707-963-9433. If Dr. Daniel Hamlin is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 1, 2003.

I have read the Privacy Policy and understand my rights contained in this notice.

By way of my signature, I provide St. Helena Chiropractic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Policy.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date



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Daniel W. Hamlin, D.C.
Michael J. Cleaver, D.C.

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and when a Chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does **not** diagnose or treat diseases. Chiropractic only has one goal:

TO LOCATE, ANALYZE AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific Chiropractic adjustment, allows the body to function at its optimal level. This allows the INNATE healing power of the body at maximum efficiency to restore, maintain and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL
SUBLUXATIONS.

WE OFFER NO TREATMENT ON CONDITION(S) OR DISEASE(S) OTHER THAN
VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST
POTENTIAL!!!

I, _____, having read the above statement, and understanding it fully, do undertake Chiropractic health care on this basis.

Signature of Patient

Date

“ Curing the cause not the symptom!”