New Patient Packet

Patient Information

HIPAA

X-Ray Consent

Patient Disclosure Info

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Welcome

Please download and fill out the below forms as completely as possible, prior to your arrival, to reduce your wait time on your initial visit.

Thank you for choosing

Carolina Health Innovations.

Personal Information

Last Name:_____First Name_____Middle Initial_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: ____-____ -_____Work Phone: ____-____-_____ Cell Phone: _____-_____-_____

Date of Birth: _____age_____ Social Security #: _____-_____-_____ Gender: ☐Male ☐Female

Email Address: _____Occupation: _____

Employer/School: _____ Phone: ____-____-_____

Spouse's Name:_____ D.O.B._____SSN_____-____-_____

Spouse's Employer:_____ Phone: ___ -____-_____

In case of emergency, contact_____ Relationship:_____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Insurance Information

Who is responsible for this account?_____Relationship to Patient:_____

Insurance Company_____Group #_____

ID #_____

Is Patient covered by additional insurance? ☐ No ☐Yes

Subscriber's Name_____D.O.B._____ SSN_____-___ -_____

Relationship to Patient_____

Insurance Company_____ Group #_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____(insurance co) and assign directly to Dr. Ken Meisten 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 doctors may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____Date_____

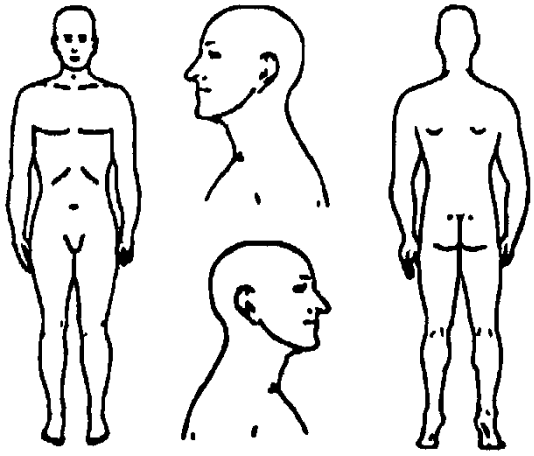
Print:Name:_____Date_____

Relationship to Patient: _____

Patient Condition

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW

(mark ALL areas with XXXXXXX)



Main reason for consulting our office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your MAJOR complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling

□ Radiating Pain □ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise,etc)?_____

What makes your pain better (ice, heat, massage, etc)?_____

Are there any other Health Concerns that you would like to talk to us about?_____

Have you ever been to a Chiropractor before? □No □Yes How long ago?_____

Whom may we thank for referring you? How did you find out about us? _____

Allergies

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin

□ Ragweed/Pollen □ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other:_____

Surgeries

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

Past Medical History

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain

□ Depression□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting

□ Fatigue □ Foot Pain □ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems

□ Hepatitis □ High Blood Pressure □ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain

□ Leg Pain □ Menstrual Problems □ Mid-Back Pain □ Minor Heart Problem □ Multiple Sclerosis

□ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's □ Polio □ Prostate Problems

□ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other _____

Medications

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

□ Other: _____

Do you take Vitamins/Supplements □ No □Yes

Family History

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy

□ Genetic Spinal Condition □ High Blood Pressure □ Heart Problems □ Multiple Sclerosis

□ Neurological Problems □ Parkinson's □ Polio □ Prostate Problems □ Stroke/Heart Attack □ Other:_____

Have you had any auto or other accidents? □ No □Yes

Describe: _____

Have you ever cracked or broken a rib? □ No □Yes - When?_____

How?_____

Do you have pain when you cough, sneeze, or bear down to go to the bathroom? □ No □Yes

Date of last physical examination: _____

Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - How many per day? _____

Do you drink caffeine? □ No □Yes - How many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Please check mark the following that you agree to:

- ❑ We can use email to communicate information to you.
- ❑ We can use voice message to communicate information to you.

Please list all parties that are available to communicate information on your behalf:

_____

I,_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Chiropractic Consent Form

The material risks inherent in Chiropractic adjustment:
As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

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 examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Signature_____ **Date**_____

X-RAY CONSENT FORM

Patient name: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:
_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities. If treatment does not improve, we will take x-rays to further evaluate the problem.

Signature:_____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant _____yes _____no _____ don't know

I could be pregnant _____yes _____no _____ don't know

My menstrual period is late _____yes _____no _____ don't know

I have an IUD _____yes _____no

I have had a tubal ligation _____yes _____no

I have had a hysterectomy _____yes _____no

I have irregular menstrual periods _____yes _____no

My last menstrual period began _____

I have begun menopause _____yes _____no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____

PATIENT RECORD OF DISCLOSURES:

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

I wish to be contacted in the following manner (Check all that Applies):

____ Home Telephone: _____ ____ Written Communication

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

____ Leave message with call-back number **ONLY** ____ O.K. to mail to my work/office address

____ O.K. to fax to this number _____ ____Work Telephone_____

____ O.K. to leave message with call-back number **ONLY** at work

Patient's Signature: _____ Date: _____

Below this line for office use only:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply in uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records PHI disclosures. Information provided below, if completed properly will constitute an adequate record. Note: Use and disclosures for TPO may be permitted with prior consent in an emergency.

Record of disclosures of Protected Health Information:

Date:	Disclosure to whom:	(1)	Description of Disclosure/Purpose of Disclosure:	By Whom Disclosure:	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T- Treatment Record: P – Payment Information: O – Healthcare Operations

(3) Enter how disclosure was made: F – Fax: P – Phone: M – Mail: O - Other