



# Silver Sound CHIROPRACTIC

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ High/Low blood pressure? \_\_\_\_\_  Single  Married  Widow(ed)  Divorced

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: Male - Female

Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_

How did you hear about us?  Internet  Friend or Family \_\_\_\_\_  Other \_\_\_\_\_

**Insurance:** Company name: \_\_\_\_\_ Address of Company: \_\_\_\_\_

Company Phone Number: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Fill in if Automobile Accident or On the Job Injury:**  
Insured's Employer: \_\_\_\_\_ Date of Injury: \_\_\_/\_\_\_/\_\_\_ Insurance Co.: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Agent Name & No.: \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_

**Race:**  American Indian  Asian  Black/African American  Native Hawaiian/Pacific Islander  White  Decline

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino  Decline **Do you smoke?**  No  Yes Did you smoke?  No  Yes

List any environmental **Allergies:**

Animals  Aspirin  Bees  Chocolate  Dairy  Dust  Eggs  Latex  Molds  Penicillin  Ragweed/Pollen  
 Rubber  Seasonal Allergies  Shellfish  Soaps  Wheat  X-Ray Dye  None  Other: \_\_\_\_\_

List any **Surgeries:**  Back  Brain  Elbow  Foot  Hip  Knee  Neck  Neurological  Shoulder  Wrist  None  
 Other: \_\_\_\_\_

List **ALL Past Medical History** conditions:

Ankle Pain  Arm Pain  Arthritis  Asthma  Back Pain  Broken Bones  Cancer  Chest Pain  Depression   
Diabete

Dizziness  Elbow Pain  Epilepsy  Eye/Vision Problems  Fainting  Fatigue  Foot Pain  Genetic Spinal Condition  
 Hand Pain  Headache  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: \_\_\_\_\_

List Type of **Medications** you are taking **AND** their **Purpose:**

1. Medication(s): \_\_\_\_\_ Purpose: \_\_\_\_\_

2. Medication(s): \_\_\_\_\_ Purpose: \_\_\_\_\_

3. Medication(s): \_\_\_\_\_ Purpose: \_\_\_\_\_

(If number of medications **EXCEEDS** three, continue list on attached page)

Are you **Allergic** to any medications? List them here: \_\_\_\_\_

**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

Please list all family members who had/has any of the problems above:

Relation: \_\_\_\_\_ Condition: \_\_\_\_\_

Relation: \_\_\_\_\_ Condition: \_\_\_\_\_

(If number of conditions **EXCEEDS** two, continue list on back)

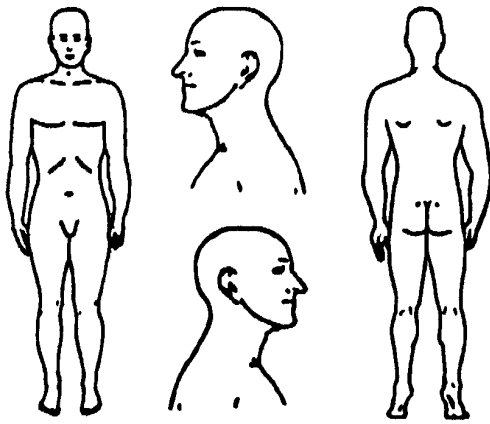
Have you had any auto or other accidents?  No  Yes Describe: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

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): \_\_\_\_\_

*PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW*



<p>Have you ever had chiropractic care?  <input type="checkbox"/> No <input type="checkbox"/> yes</p> <p>When? _____</p> <p>Why? _____</p> <p>Where? _____</p> <p>Were X-rays taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>When was your last adjustment?          _____</p>	<p>Doctor Notes:</p>
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What is your major complaint? \_\_\_\_\_ Date problem began? \_\_\_\_\_

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

IS YOUR CONDITION?  getting **BETTER**  getting **WORSE**  **NOT CHANGING**

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

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

Please rate the intensity of your pain:  Minimum  Mild  Moderate  Severe  Unbearable  None

Describe the nature of your symptoms:  Burning  Dull  Numb  Radiating  Sharp  Shooting  Stabbing

Throbbing  Tightness  Tingling  Other: \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc.)? \_\_\_\_\_

What are your expectations?  Become pain free  Explanation of condition  Learn to care for on my own

Reduce symptoms  Resume normal activities

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)

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

## **HIPAA Notice of Privacy Practices** **Silver Sound Chiropractic**

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and may relate to your past, present or future physical or mental health condition and any related health care services.

### 1. Uses and Disclosures of Protected Health Information.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. Example: obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may disclose your protected health information to medical school! students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary in order to contact you for appointment reminders.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as Required By Law. Public Health issues, communicable Diseases, Abuse or Neglect, food and Drug Administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donations, research, criminal activity, military activity, national security, workers' compensation and inmates required uses and disclosures. We must make disclosures to you and when required by the Secretary or the Department of Health and Human services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that

your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or any protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of the notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You may file a complaint with us by notifying our privacy contact of your complaint. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Silver Sound Chiropractic Financial Agreement

Let's clarify the financial aspects of your care so we can direct all of our attention to balancing your body. Outlined below is our Financial Agreement.

**Third Parties:** If you have health insurance, were injured on the job, in an automobile accident or some other personal injury, you may have other options. In general, we expect payment of deductibles, co-payments and co-insurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.

**All co-payments must be paid at the time of service. There will be a \$5 fee for all payments not made the day of service.**

I am responsible for obtaining any and all required referrals for service.

I am responsible for knowing my co-pay, how many visits I am allowed, and if I need prior authorization before treatment from my insurance carrier.

I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until **after** the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.

I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.

The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY:** I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for non-covered services. The Provider will file my insurance claim only as a courtesy.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the Provider to release any information required to process my claim.

**Individual Consideration:** If there is financial hardship associated with receiving care in our office, please understand that we have never refused any client due to their financial situation. We will however come to some agreement for payment of services that both parties can agree on.

**Billing:** We have a payment at time of service policy however we understand that circumstances sometimes change. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. Balances beyond 30 days will be charged a billing fee of 5% per month, plus any legal or collection fees. A check returned from our financial institution is subject to a returned check fee. The current fee is \$25.00 per return.

**Missed Appointments:** I understand that if I have an appointment and fail to cancel it at least twenty-four hours in advance, during the business hours of this office, that I will be charged a \$25 fee for the doctor's time. I understand that insurance companies do not typically pay this fee and that this responsibility is mine alone.

**Agreement:** This is the entire financial agreement between Starnes Chiropractic and the patient below. I have read this agreement, understand it and agree with its provisions.

Patient's Name Printed: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Guardian Signature if applicable: \_\_\_\_\_ Date Signed: \_\_\_\_\_