ihc Integrative Health Chiropractic

PATIENT INFORMATION

DATE :_____

NAME (Mr. Mrs. Miss Ms.)_____HOME PHONE #( )_____

CELL/MOBILE OR ALTERNATE #( )_____E-MAIL_____

HOME ADDRESS_____ _____ CITY _____ STATE_____ZIP_____

MARRIED____SINGLE____OTHER_____AGE_____DATE OF BIRTH_____/_____/_____

CONTACT IN CASE OF AN EMERGENCY_____PHONE #( )_____

OFFICE ADDRESS_____WORK PHONE #( )_____

PREVIOUS CHIROPRACTIC CARE____YES_____NO DOCTOR'S NAME_____

NAME OF YOUR INSURANCE COMPANY_____ PHONE# _____

POLICY # _____ GROUP# _____

IS THIS DUE TO AN AUTO/WORK ACCIDENT? _____ YES _____ NO WHEN DID IT HAPPEN? _____

SOCIAL SECURITY NUMBER_____

WHOM MAY WE THANK FOR THE REFERRAL?_____

PATIENT INTAKE

PATIENT NAME_____WHAT YOU LIKE TO BE CALLED_____

ANY PREVIOUS CHIROPRACTIC CARE Y N / HOW LONG GO_____

WHAT IS YOUR MAJOR COMPLAINT_____

WHEN DID IT BEGIN_____HOW DID IT BEGIN_____

HAVE YOU HAD SIMILAR CONDITIONS IN THE PAST/WHEN_____

PLEASE CIRCLE THE QUALITY OF YOUR PAIN- DULL ACHING SHARP SHOOTING BURNING NUMBNESS TINGLING THROBBING NAGGING

GRADE INTENSITY/SEVERITY (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE)

DOES THE PAIN RADIATE OR TRAVEL (SHOOT) TO ANY AREAS OF YOUR BODY/ WHERE_____

DOES ANYTHING AGGRAVATE YOUR COMPLAINT_____

DOES ANYTHING MAKE IT BETTER_____

IS THE PAIN CONSTANT_____ COMES AND GOES_____ DOES PAIN INTERFERE WITH WORK_____SLEEP_____DAILY ROUTINE_____

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR THIS COMPLAINT_____MEDS_____PHYSTHERAPY_____SURGERY____OTHER

OTHER DOCTORS WHO HAVE TREATED THIS CONDITION_____DC____DO____MD_____

HAVE YOU EVER BEEN IN A AUTO ACCIDENT_____PAST YEAR_____PAST FIVE YEARS_____OVER FIVE YEARS_____NEVER

PLEASE DESCRIBE_____

HAVE YOU HAD ANY OTHER PERSONAL INJURIES, JOB RELATED INJURIES OR ACCIDENTS THAT YOU THINK MAY OR MAY NOT BE

RELATED_____PAST YEAR_____PAST FIVE YEARS_____OVER FIVE YEARS/DESCRIBE_____

ARE YOU TAKING ANY DAILY MEDICATIONS/EXPLAIN_____

HOW MANY CUPS OF COFFEE OR OTHER CAFFEINATED BEVERAGES DO YOU CONSUME EACH DAY_____

WHAT VITAMINS/ SUPPLEMENTS DO YOU CURRENTLY TAKE_____

DO YOU SMOKE? Y N WHAT TYPE OF EXERCISE DO YOU PERFORM_____

HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME EACH DAY_____

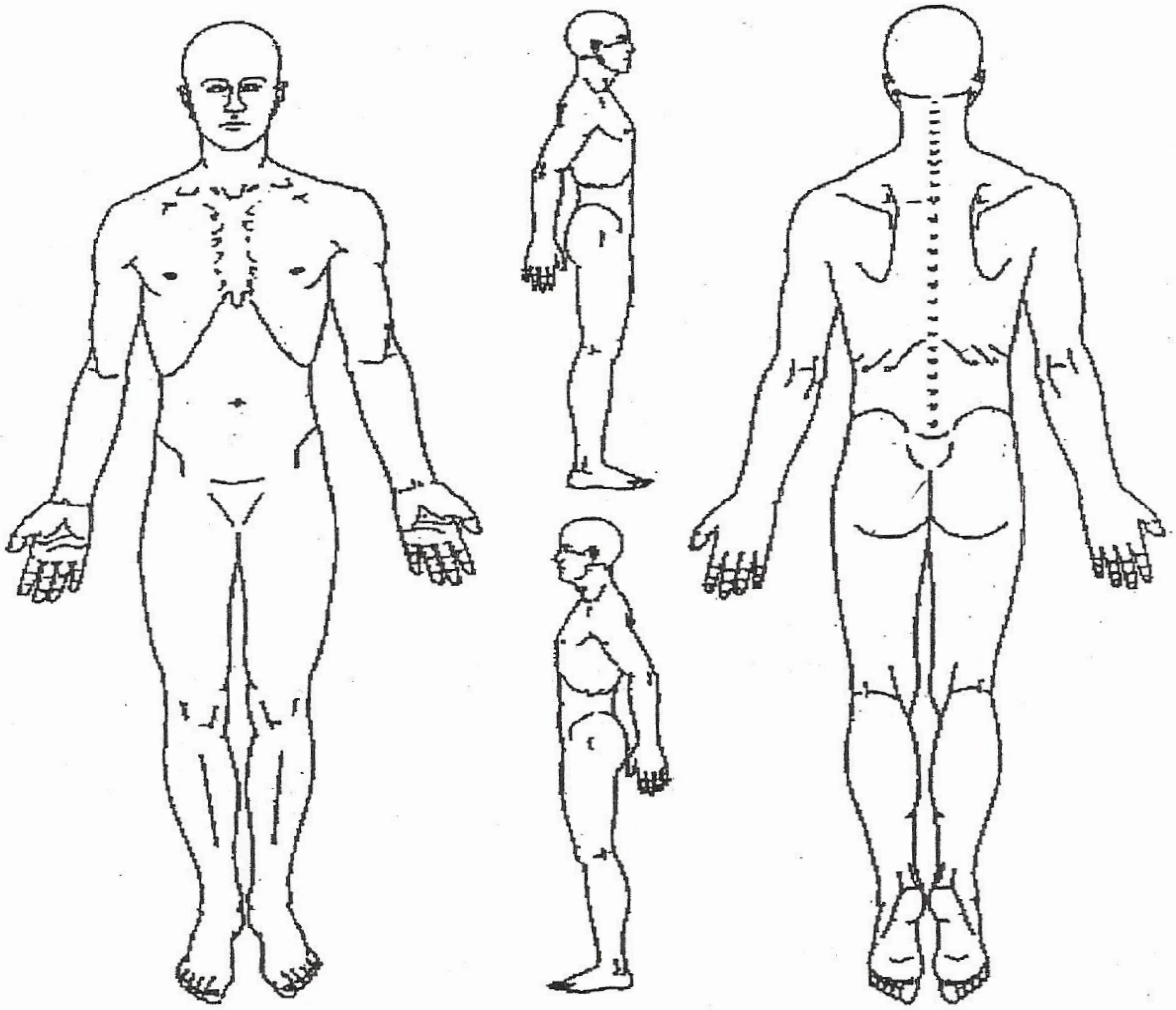
HOW OFTEN DO YOU EXERCISE EACH WEEK_____NO EXERCISE_____1 X WEEK_____2 X WEEK_____3 X WEEK_____DAILY

NOTE: IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED. WE REQUIRE 24 HOUR NOTICE ON CANCELATIONS TO AVOID CHARGES.

SIGNATURE_____

BY SIGINING I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTHCARE, ADVICE, AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR. IN THE EVENT THAT INSURANCE DOES NOT COVER ALL CHARGED PROCEDURES, THE PATIENT IS THEN RESPONSIBLE FOR THE UNPAID BALANCE.

On the diagram below, please indicate where you are experiencing pain or other symptoms



A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

Integrative Health Center

317 Delaware Kansas City, MO 64105

Integrative Health Center uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of INTEGRATIVE HEALTH CENTER.

How Integrative Health Center May Use or Disclose Your Health Information

For Treatment Integrative Health Center may use your health information to provide you with medical treatment or services. For example, a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record action taken by them in the course of your treatment and note how you respond to the action.

For Payment: Integrative Health Center may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: Integrative Health Center may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

Evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: Integrative Health Center may use your information to provide appointment reminders.

Required by Law: Integrative Health Center may use and disclose information about you as required by law.

For example, Integrative Health Center may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be used or disclosed for specialized government functions such as protection of public officials reporting to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other Uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Integrative Health Center has taken action in reliance on such.

Your Health Information Rights

You have the right to: Request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. § 164.522; however, Integrative Health Center is not required to agree to a requested restriction;

Obtain a paper copy of the notice of information practices upon request;

Inspect and obtain a copy of your health record as provided in 45 C.F.R. § 164.526;

Request that your health record be amended as provided in 45 C.F.R. § 164.526;

Request communications of your health information by alternative means or at alternative locations; and Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. § 164.528.

Complaints

You may complain to Integrative Health Center and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Integrative Health Center

Integrative Health Center is required by law to:

Maintain the privacy of protected health information; Provide you with this notice of its legal duties and privacy practices with respect to your health information;

Abide by the terms of this notice; Notify you if we are unable to agree to a requested restriction on how our information is used or disclosed; Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and Integrative Health Center reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon request.

Contact Information

If you have any questions or complaints, please contact:

Dr. W. Robert Williams, D.C.
Privacy Officer
317 Delaware Street
Kansas City, MO 64105
Phone: 816-283-8400

Effective Date: February 15, 2003

I,_____,
Hereby acknowledge receipt of this Notice of Privacy Practices given to me.

Signed:_____

Date:_____

If not signed, reason why acknowledgement was not obtained:
_____

Staff witness seeking acknowledgement:

_____

Date:_____