

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced

Patient employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person responsible employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Reason for Visit

Have you ever seen a chiropractor?  Yes  No If yes, when and why? \_\_\_\_\_

Your reason for *this* visit: \_\_\_\_\_

Please describe your current pain and its location: \_\_\_\_\_

When did symptoms begin (date)? \_\_\_\_\_ Have you had similar conditions in the past? \_\_\_\_\_

Is pain getting:  Worse  Better  Same  Comes and goes How often do you have this pain? \_\_\_\_\_

Have you been treated by a medical physician for this condition? \_\_\_\_\_

If so, when and where? \_\_\_\_\_

Activities or movements that are difficult/painful to perform:  Sitting  Walking  Bending  Lying down  Lifting

Type of pain:  Sharp  Dull  Throbbing  Aching  Burning  Tingling  Numbness  Cramping  
 Stiffness  Swelling  Other \_\_\_\_\_

Is pain interfering with:  Work  Sleep  Daily Routine  Recreation

Please complete both sides.



## Health History

Please list any medication (including pain killers) you are taking: \_\_\_\_\_  
 \_\_\_\_\_

Please list any serious injuries or surgeries you have had in the last 10 years:

	Date
Falls	_____
Head Injuries	_____
Broken Bones	_____
Dislocations	_____
Surgeries	_____
Other Serious Injuries	_____

Women: Are you pregnant?  Y  N If so, how far along? \_\_\_\_\_ Nursing?  Y  N

## Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke        | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Ringing in Ears           | <input type="checkbox"/> Ulcer/Colitis               |
| <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Frequent Neck Pain       | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Gout                        |
| <input type="checkbox"/> Alcohol/Drug Abuse         | <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Diabetes/Tuberculosis     | <input type="checkbox"/> Numbness, where? _____      |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Wrist Pain               | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Tingling, where? _____      |
| <input type="checkbox"/> Shingles                   | <input type="checkbox"/> Shoulder Pain            | <input type="checkbox"/> Emphysema/Glaucoma        | <input type="checkbox"/> Muscle Spasms, where? _____ |
| <input type="checkbox"/> Psychiatric Problems       | <input type="checkbox"/> Arm Pain                 | <input type="checkbox"/> Kidney Problems           |  |
| <input type="checkbox"/> Difficulty Breathing       | <input type="checkbox"/> Leg Pain                 | <input type="checkbox"/> Artificial Bones/Joints   |  |
| <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Lower Back Problems      | <input type="checkbox"/> Cancer                    |  |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Severe/Frequent Earaches | <input type="checkbox"/> HIV Positive/AIDS         |  |

## Personal Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**



# ProChiropractic

31815 Southfield Rd. Suite 17, Beverly Hills MI 48025

## INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby consent to request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays completed on me (or the patient named below for whom I am legally responsible) by the chiropractic doctor who now or in the future may treat me while employed by working or associated with or serving as back-up for the doctor of chiropractic named below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic, named below, and/or with the other office or clinic personnel the nature and purpose of chiropractic adjustment and other procedures. I understand that results are not guaranteed.

I understand and have been informed that as in the practice of medicine and in the practice of chiropractic there are some risks to treatment including, but not limited, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interest.

I have read, or have had read to me the above consent, I have also had an opportunity to ask questions about its content, and by signing below I agree to the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions, for which I seek treatment.

**To be completed by patient. To be completed by patient representative, if necessary, e.g. patient is a minor or physically or legally incapacitated.**

Print Patient Name \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

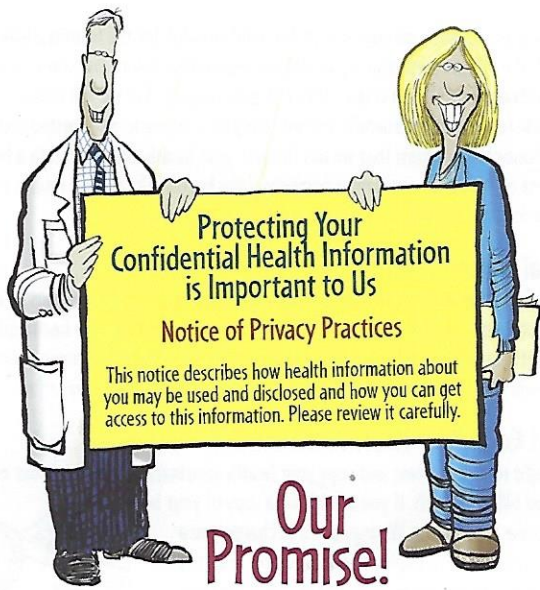
Date \_\_\_\_\_

### **Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of ProChiropractic and Dr. Ray's "Notice of Privacy Policy's". Detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I place no additional restriction(s) concerning personal medical information. I may revoke this authorization in writing at any time.

4/7/20





Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.



### How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

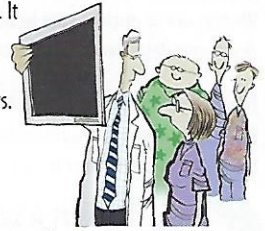
### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for

students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



### In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

### To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

### NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

### As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.



### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

### Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

### Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

**Dr. Raymond Hillenbrand / ProChiropractic**

31815 Southfield Rd., Suite 17 • Beverly Hills, MI 48025 • (248) 792-9736



## Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

## Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.



### To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

### To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

## For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

## In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

## Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

## PATIENT RIGHTS

You have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations



## Patient Acknowledgment

Patient Name(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For additional information about the matters discussed in this notice, please contact our Privacy Officer.



purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

## Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.



## Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

## Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

## Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

## Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

## Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

## Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013