

Vanderbilt Family Chiropractic

DATE _____

NAME OF PATIENT: _____ BIRTH DATE: _____
ADDRESS _____ CITY/STATE _____ ZIP _____ H
HOME PHONE: _____ CELL PHONE: _____
Email: _____ REFERRED BY: _____

AGES OF CHILDREN: _____ circle one: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER: _____ JOB DESCRIPTION _____

WORK ADDRESS: _____

WORK PHONE: _____

INSURANCE PROVIDER: _____

PRIMARY INSURED NAME: _____ INSURED'S BIRTHDATE: _____

INSURANCE: GROUP # _____ IDENTIFICATION # _____

CHIEF COMPLAINT: _____

PATIENT EXPLANATION OF INCIDENT: _____

DATE OF ONSET: _____ GRADUAL OR SUDDEN _____

ON THE JOB YES NO DAYS OFF WORK _____

AUTO ACCIDENT YES NO DAYS OFF WORK _____

LOCATION OF PAIN (INCLUDING EXTREMITY RADIATION) _____

FREQUENCY/DURATION OF PAIN _____

TYPE OF PAIN: SHARP, JABBING ACHE Other _____ SEVERE MODERATE

PAIN walking standing sitting laying WORSE IN A.M. OR P.M.

WHAT MAKES IT BETTER? _____

OTHER CHIROPRACTORS CONSULTED _____ MD _____

SLEEPING HABITS: ON BACK ON SIDE SIDE W/ ARM EXTENDED ON STOMACH other _____

PREGNANT: YES or NO DATE OF LAST MENSTRUAL CYCLE: _____

MEDICAL HISTORY

ACCIDENT/INJURIES: _____

SURGERIES: _____

MEDICATIONS/SUPPLEMENTS: _____

EXERCISES: _____

Additional patient record on file

Vanderbilt Family Chiropractic

North Barrington, IL

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and attorney fees. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize Vanderbilt Family Chiropractic to release any information to my insurance company/attorney acquired in the course of my examinations or care. I understand that a photocopy of the above assignment and authorizations will be deemed as valid as the original.

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 disease. Chiropractic has only one goal: to locate, analyze, and correct spinal interference to the nervous system (nerve pressure). 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 optimum level. This allows the inborn healing power of the body to work 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 of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

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

Patient's Signature _____ **Date** _____

Consent to chiropractic care for a minor

Guardian/Spouse's Signature _____ **Date** _____

- 1. Please list your Health Goals, for example, increasing sports performance or minimizing sick days.

- 2. Please complete this sentence: I view health as (or the definition of health is):

- 3. These are the things that I am most concerned about in visiting a chiropractor:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, the patient signed below, have received a copy of this office's Notice of Privacy Practices.

{Signature}

{Date}



Vanderbilt Family Chiropractic

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14th, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as but not limited to voicemail messages, postcards, or letters.

Office Related Articles: We may use the address provided by you to send office related information such as but not limited to birthday postcards, patient recall letters, thank you postcards, sympathy cards, and newsletters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee for expenses such as copies and staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Brian Vanderbilt

Telephone: 847/719-2225