

Confidential Patient Data

Dr. Harvey Abrams D.C. FIAMA
801 S.Power Rd. Ste 107
Mesa, AZ 85206

Today's Date: _____
Time: _____
Received by: _____

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Alt Phone: _____
Social Security #: _____ E-Mail: _____
Age: _____ Male Female Marital Status: Married Single Divorced Separated Other
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation _____ Your Employer: _____

Referred to this Office by: Yellow Pages Mail Clinic Location
 Friend/Family Member - Name? _____

Payment for Services will be by:
 Cash Check Credit Card Health Insurance Automobile Insurance Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____
Insured's Social Security #: _____ Employer's Phone #: _____
Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

ACCIDENT HISTORY:

Job Auto Other 1. _____ Date: _____
For Auto: Cross-streets and City, State _____
 Job Auto Other 2. _____ Date: _____
For Auto: Cross-streets and City, State _____
 Job Auto Other 3. _____ Date: _____
For Auto: Cross-streets and City, State _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please List Your Complaints:

Rate it 1-10, with 1 being least serious? How Long?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT CONSISTANT UNCHANGED

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ____MONTH(S) ____YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD LIFTING
- SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- Blurred Vision Buzzing In Ears Cold Feet Cold Hands Cold Sweats Concentration Loss/Confusion
- Constipation Depression /Weeping Spells Diarrhea Dizziness Face Flushed Fainting Fatigue Fever
- Head Seems Too Heavy Headaches Insomnia Light Bothers Eyes Loss Of Balance Loss Of Smell
- Loss Of Taste Low Resistance To Colds Muscle Jerking Numbness In Fingers Numbness In Toes
- Pins And Needles In Arms Pins And Needles In Legs Ringing In Ears Shortness Of Breath Stiff Neck Stomach Upset

Patient's Signature: _____ **Date:** _____

HIPAA PRIVACY COMPLIANCE POLICY EFFECTIVE 4/01/03

We Will Keep Your Medical Information Confidential

Rehabilitation Chiropractic Care, PC
801 S. Power Rd. Ste 107 Mesa AZ 85206 (480) 396-4400

THIS NOTICE IS PRESENTED IN COMPLIANCE WITH FEDERAL HIPAA REQUIREMENTS FOR HEALTH CARE PROVIDERS & DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

HIPAA "The privacy provisions of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), apply to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. The Department of Health and Human Services (HHS) has issued the regulation, "Standards for Privacy of Individually Identifiable Health Information," applicable to entities covered by HIPAA. The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation. (See the Statement of Delegation of Authority to the Office for Civil Rights, as published in the Federal Register on December 28, 2000.)"

Question: What is this HIPAA compliance form all about?

Answer: HIPAA requires all Health Care Practitioners to keep your health related information private, releasing us to release pertinent information to:

1. Your insurance company or other 3rd party payer, so they can pay your bill.
2. Your other doctors, for information you want them to have from us.
3. Your attorney or anyone else you request and authorize us to release it to.
4. Our business partners. Examples: Outside billing companies, outside marketing companies that might produce and mail our newsletters, etc. If we use any such company, they too will maintain the same level of privacy we maintain.
5. Your legal representative(s), should you for any reason become unable to speak and or act for yourself in making health care related decisions.
6. Your providers of emergency treatment as consistent with our awareness of your needs and the doctors best judgment.
Example: You are in the emergency room and they need medical information about you from us.
7. Your family, friends or others that may answer your phone, read your mail, or otherwise communicate with us as part of our exchanging information with one another that is necessary to your care and relationship with this office. *Examples:* We can call your home and leave a message for you on your answering machine or with any person that answers. We can send you a fax or e-mail that might be read by any other person with access to your fax or e-mail. We can leave a message for you at work on any recording device or with any person limited to our name, phone number, and the level of necessity / urgency that you contact us.
8. You should be aware that government agencies can abridge your right to privacy and legally require us to release information even against your will. *Examples:* In cases of child abuse where the parent does not authorize the release of this information. In instances where you might be a threat to yourself or others (i.e.: suicidal). The office will obey the law in respect to any current or future requirements to report or release information.

YOU CAN REVIEW, RESTRICT AND/OR REVOKE ACCESS TO YOUR INFORMATION

Space is provided on the back of this form for you to list any objections, restrictions, limitations etc. that you want to apply to your information in our office. This can include the names of individuals that are to have no or limited access to your information and if limited the parameters of that limitation. *Example:* The name of your 14 year old child where you allow that we can leave messages for you but not discuss the details of your health. You can update this information at any time, in person or over the phone. *Example:* You still live with a significant other but you no longer want us to leave any messages with them.

By signing below I acknowledge that I understand and agree to the above and can request a copy of this notice. I have indicated any restrictions I wish to apply to my records on the reverse side of this page.

AGREEMENT AND SIGNATURE AS OF ____/____/____

Patients Name: _____ Signature of Patient: _____
Parent or Guardians Name: _____ Signature of Parent or Guardian: _____

Use the back of this page to list additional objections, restrictions, and limitations for your information.

Welcome to Rehabilitation Chiropractic Care, P.C.

“In The Business of Health”

Dear New or Returning Patient:

Welcome to the health care facility of Rehabilitation Chiropractic Care P.C. this facility is primarily interested in teaching the benefits of receiving preventative chiropractic care, proper nutrition and rehabilitative exercise to our patients. Our licensed professional staff will treat you with modern treatment modes.

Terms of Agreement:

Patient understands and acknowledges the following criteria:

1. **Consent for Chiropractic Treatment** – I hereby consent to the performance of spinal manipulations, acupuncture and any other chiropractic procedures, including but not limited to examination tests, diagnostic x-rays, physiotherapy techniques, nutritional advice and rehabilitative exercise on me.
 - a. **Minor consent** – I hereby give Rehabilitation Chiropractic Care P.C. or staffs consent to treat myself/my minor child. I am welcome to observe the treatments.
2. **Risk** – I understand that as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fracture, 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. I understand that the chiropractor can not be expected to anticipate all risks and complications associated with manipulations but will rely on their expertise of judgment and training during the course of the procedure(s) which the doctor feel at the time, based upon the facts then known, are in my best interest.
3. **Results** – I understand that results are not guaranteed. I have read () or have had read to me () the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have hereby consented to the treatments recommended by the doctor. I intend for this consent to cover the entire course of my treatment for my present condition(s) and for any future condition(s) for which I seek treatment.
4. **Nutritional Advise** – I understand that I am not receiving a medical diagnosis or treatment procedure of my illness or disease. Any supplements, herbs, or homeopathic remedies that may be suggested are not to be misconstrued as prescription or curative of any disease process. All consultations are of a nutritional nature and intended to maintain a state of good health and do not involve diagnosing or prescribing remedies for the treatment of disease.
5. **Accurate Information** – I acknowledge that all information is factual and complete. After reading and filling out my patient intake forms, I state that all of the information given is accurate and reflects my current health status. To facilitate safe, effective chiropractic care, I understand that my records must be up-to-date. I am responsible in notifying the doctor and staff of any changes to my healthcare to include but not limited to: illness, surgeries, accidents, or other injuries.
6. **Treatment Plan and Assessment** – After detailed evaluation of your current symptomatology and special health concerns, the doctor will go over this plan with you totally and stress the importance of the patient’s diligent follow-through. This plan has been customized for your specific health concerns and treatments of such and we ask for your participation and active commitment for optimal results. Failure to complete the recommended plan may result in set backs in your care. I understand the doctor and staff are committed to my treatment and I will make appointments in conjunction with this plan.
7. **Termination** – I understand that the doctor has the right to select their cases and patients. The patient has the right to continuity of care once the doctor has agreed to treat the patient. The chiropractor may terminate the patient-doctor relationship only when the patient has been given reasonable notice. It is permissible for the doctor to terminate the patient-doctor relationship when the patient fails to cooperate.

8. **X-Rays (who owns them?)** – According to the Chiropractic Board, custody of patient records is as follows: Interspective material, including x-rays taken during the course of chiropractic treatment, is the work-by-product of the physician and is the doctor's property. X-ray reports will be provided to other physicians with a medical release form from the patient upon request.
9. **Payment Terms** – I understand that payments (including insurance deductibles, co-insurance and co-payments) are due at time of service, unless otherwise agreed to in writing. The patient is responsible for their medical bills. I further understand that interest and/or late payment fees will be charged to delinquent accounts. Payment is due upon receipt on invoice. Payment arrangements are available upon advanced request.
10. **Appointment Policies and Fees** – I understand that I am expected to be on time for my appointment and if I am late I will be asked to wait or reschedule for a later time the day if possible. I understand that I must notify the office 24 hours in advanced in order to cancel my appointment and if I fail to do so, my account will be charged a late fee which is posted in the office.
11. **Release of Records** – A Chiropractic physician shall make available within a reasonable time to a patient or a third party upon the patient's written request, copies or summaries of medical records and originals or copies of the patient's x-rays. The Chiropractic physician shall preserve a patient's medical records from disclosure and will release them only on a patient's written consent stating to whom the records are being released or as required by State or Federal law. I authorize Rehabilitation Chiropractic Care, P.C. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for re-imbusement of charges incurred by me as a result if professional services rendered at by this clinic and I hereby release you of any consequences.
12. **Arbitration** – I understand and acknowledge the following: any claims, controversy or dispute as to medical malpractice between doctor (staff) and patient, whether any medical services rendered under this contract were unnecessary or unauthorized, or were inappropriate, negligently or incompletely rendered which is not resolved through good faith negotiations shall be resolved by arbitration in accordance with the Federal Arbitration Act 12-1501. Both parties to contract by entering into it are giving up their constitutional right to have such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. A neutral arbitrator, who is a resident of the state in which the clinic operates, shall conduct the arbitration under the current rule of the Arizona Arbitration Association and all expedited procedures prescribed by the AAA ruler shall apply. The Arbitrator shall have authority to award compensatory damages only. Any claims, controversy or dispute as to medical malpractice between doctor (staff) and patient. The arbitrators' award shall be final and binding and may be entered in any court having jurisdiction thereof. Each party to the arbitration shall pay such party's, pro-rata share of the expenses and fees of the neutral arbitrator together with other expenses of the arbitration incurred or approved by the neutral arbitrations not included counsel fees, or other expenses incurred by a party for such party's own benefit.

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

If a dispute arises out of or relates to the contract, or is breached and the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Rules, before resorting to arbitration, litigation, or some other dispute resolution procedure.

Signature

Today's Date