

Patient Information Form

Name (Last, First, Middle)	Birth Date	Age	Marital Status
Address	City, State, Zip		Home Phone
Employer Name and Address	Occupation	Phone	
Nearest Relative Not Living With You and a Phone Number:			Your SSN#:
Name of Person Who Referred You:		Family Physician and Phone Number:	
Parents Names (If Minor):	Signature of Parent (Required):		
Describe Presenting Symptoms in Detail:			
If Accident, list Date of Injury and Details of Accident:			
Is Your Condition: (circle one) Getting Worse Staying the Same Improving		Date Condition Began:	
Check or Circle Activities Which Make Your Condition Worse: Sitting Standing Lying Down Exercise Walking Work Other			
Name of Doctor or Hospital Currently Treating You for this Condition: (if any)			
Reason for Transferring Care to Our Facility			
Have You Ever Had a Similar Condition? If So, Please Describe When and Where:			
Name of Insurance Company (if any) (We Will Copy Your Insurance Card)			
Spouse's Name:		Children's Name:	
Patient's Signature:		Date:	

Check the Following Which You Have Had and **Underline** Any You Have Presently

Gastrointestinal

- Belching of Gas
- Colon Trouble
- Constipation
- Diarrhea
- Excessive Appetite
- Poor Digestion
- Nausea
- Pain over Stomach
- Vomiting
- Vomiting of Blood
- Gall Bladder Trouble
- Hemorrhoids
- Liver Trouble
- Jaundice
- Intestinal Worms
- Other _____

Genito-Urinary

- Frequent Urination
- Painful Urination
- Difficulty Starting Urine
- Inability to Control Urine
- Pus in Urine
- Blood in Urine
- Bed Wetting
- Kidney Infection
- Kidney Stones
- Prostate Trouble
- Other _____

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Previous Heart Trouble
- Fast Heart Beat
- Slow Heart Beat
- Stroke
- Swelling Ankles
- Varicose Veins

Respiratory

- Chest Pain
- Chronic Cough
- Difficulty Breathing
- Frequent Colds
- Spitting up Blood
- Spitting up Phlegm

Female Problems

- Congested Breasts
- Cramps or Backache
- Excessive Flow
- Hot Flashes
- Irregular Cycles
- Lumps in Breasts
- Miscarriage
- Painful Intercourse
- Painful Menstruation
- Vaginal Discharge

Eyes-Ears-Nose-Throat

- Crossed Eyes
- Pain in Eyes
- Poor Vision
- Deafness
- Earaches
- Ear Discharge
- Ringing in Ears
- Nasal Discharge
- Nasal Obstructions
- Nose Bleeds
- Dental Decay
- Difficulty Swallowing
- Hoarseness
- Sore Throat
- Tonsillitis
- Asthma
- Enlarged Thyroid
- Gum Trouble
- Hay Fever

Skin

- Boils
- Bruising
- Dryness
- Exzema
- Hives
- Itching
- Sensitive Skin
- Skin Eruptions

Muscles and Joints

- Backache
- Poor Posture
- Foot Trouble
- Hernia
- Painful Tailbone
- Stiff Neck
- Swollen Joints
- Tremors
- Weakness

General

- Allergies
- Fainting
- Weight Loss
- Headaches
- Loss of Sleep
- Numbness
- Nervousness
- Arthritis
- Epilepsy
- Gout
- Sciatica
- Diabetes
- Polo
- Rheumatic Fever
- Tuberculosis
- Venereal Disease
- Cancer

Date of most recent physical examination: _____

List any Prescriptions: _____

List any Surgeries: _____

	Living	Dead	Age	Died As the Result of	Past Health History
Father					
Mother					
Brothers					
Sisters					

Williams Chiropractic Clinic

Effective Date: 04-14-03

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.

Williams Chiropractic Clinic is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization except as described in this Notice.

How Williams Chiropractic Clinic May Use or Disclose Your Health Information

Williams Chiropractic Clinic protects the privacy of your health information. The law permits Williams Chiropractic Clinic to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by the Clinic will be used to provide services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required by Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensations programs. Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders and other information about treatment alternatives or health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for you care.
- *Disclosure to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications - We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

When Williams Chiropractic Clinic May Not Use or Disclose Your Information

Except as described in this Notice of Privacy Practices, Williams Chiropractic Clinic will not use or disclose your health information without your written authorization. If you do authorize Williams Chiropractic Clinic to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information

- You have the right to request restrictions on certain uses and disclosures of your health information. To make such a request, you must complete the **Restriction of the Use of Patient Information** form and the request will apply only to the location providing services. Williams Chiropractic Clinic is not required to agree to the restriction that you requested.
- You have the right to inspect and copy your health information as long as the Clinic maintains the health information. Your health information usually will include billing records. To inspect or copy your health information, you must complete a **Request to Inspect Medical Records** form and submit the request to the location that provided your services. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- You have the right to request that Williams Chiropractic Clinic amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request to Amend Medical Records** to the location providing services. Williams Chiropractic Clinic is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.
- You have a right to receive an accounting of disclosures of your health information we have made after April 14, 2003 for most purposes other than treatment, payment, health care operations, information provided to you, and certain government functions. To request an accounting, you must complete a **Request for Accounting of Disclosure** to the location providing services. You must specify the time period but may not be longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must complete a **Request for Alternative Communication** to the location providing services and will be good for only the location providing services. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, contact the location that provided you services or submit a written request to Williams Chiropractic Clinic, HIPAA Coordinator, 607 Oakland Avenue, Mt. Lake Park, Maryland 21550

Changes to this Notice of Privacy Practices

Williams Chiropractic Clinic reserves the right to amend our practices and this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain. Until such amendment is made, Williams Chiropractic Clinic is required by law to comply with this Notice. The revised notice will be posted in the Clinic and a paper copy will be available upon request.

For More Information or to Report a Problem

If you have questions or would like additional information about the Clinics practices, you may contact the HIPAA Coordinator at the address above. If you believe your privacy rights have been violated, you may file a written complain, for which there will be no retaliation, using our form with HIPAA Privacy, 922 W. Walnut, Rogers, AR 72756-3540, or with the Secretary of Health and Human Services.

By signing below, I acknowledge that I have received the Clinics Privacy Notice

Signature of Patient or Authorized Representative

Date



WILLIAMS CHIROPRACTIC CLINIC

607 Oakland Avenue
Mountain Lake Park, MD 21550

Dr. Ronel R. Williams
Telephone (301) 334-3180
Fax (301) 334-3182

Consent to Exam and Treat

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient.

The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extra spinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, soft tissue manipulation, taping, exercise, nutritional supplementation and any other procedures as prescribed by the doctor.

The staff of this office does everything within their power to minimize any risk involved in any procedure. In spite of that, there is a very small risk of complications. These complications can include, but not limited to, increased pain, swelling, bruising, sensory changes, bleeding, fracture, dizziness, weakness or stroke. Again, complications are exceedingly rare; however, it is necessary to inform you of their possibility.

I have read the above information and by my signature give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

Printed Name: _____

Signature: _____ Date: _____

Financial Responsibility Agreement

I fully understand that the Williams Chiropractic Clinic has agreed to complete and submit insurance claims on my behalf to my insurance carrier. In the process of filling such claims, it is often necessary to release copies of my records. I give my full and complete permission to Williams Chiropractic Clinic to release my records to any party necessary for my treatment or payment of such.

I also understand that the submitting of a claim in no way guarantees payment for the claim. I therefore, understand and acknowledge that I also am fully and completely responsible for the total bill.

I agree to pay Williams Chiropractic Clinic for any and all charges, which result from my care, in the office at the time the care is rendered. (Exceptions will only be made with prior approval from the Doctors). In the event that any overpayment occurs, Williams Chiropractic Clinic will credit your account or refund said funds, whichever you prefer.

Responsible Party/Patient Signature

Date

Witness

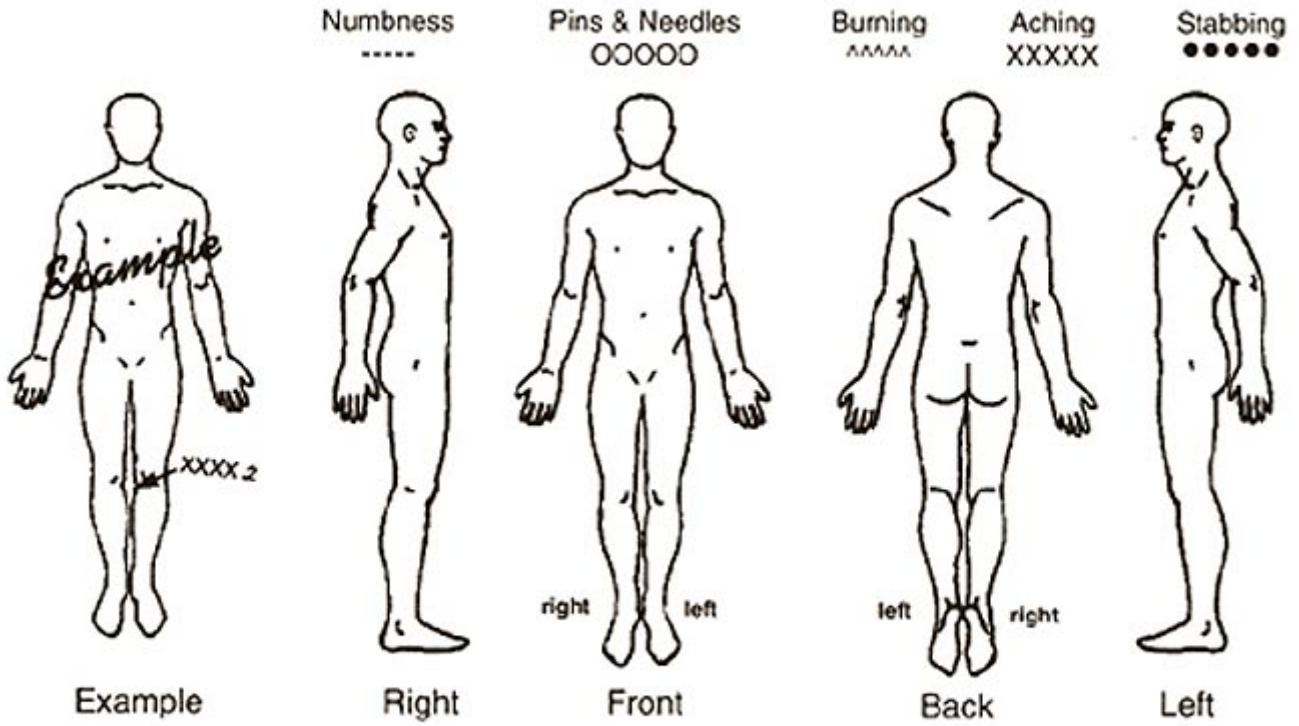
Date

Name: _____

Date: _____

Show Us Where It Hurts

Please mark **area(s)** of injury or discomfort as shown below in the example.



Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

