

WELCOME TO STRAIGHT CHIROPRACTIC

Name:	Today's Date:	
What You Prefer to be Called:		
Mailing Address:	City:	Zip:
Home Phone:	Work Phone:	Cell:
Email Address (for the doctors weekly wellness tip):		
Birth Date:	Age:	Social Security #:
How did you learn about our office?		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Spouse's Name:		
Name and Ages of Children:		
Patient's Employer/Business:		
Occupation:		
Recent Work-Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No Approximate Last Visit Date:		

Please check reasons for pursuing chiropractic care:

- ___ I'm continuing ongoing care from another chiropractor.
- ___ I'm interested in wellness and natural health care.
- ___ I'm concerned about my health and I'm looking for answers.
- ___ I have a specific condition that concerns me.

Explain condition or symptom:

- ___ I want to improve my immune function.
- ___ I have no idea why I'm here. Please take the time to explain to me what you do.

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

- Headaches/Migraines Asthma Sleep Problems Menstrual Problems Weight Problems
- Postural Imbalance Gas/Bloating Dizziness/Fainting Ringing in Ears Allergy/Sinus Problems
- Bladder Trouble Ear Infection Frequent Colds Arthritis Intestinal Problems
- High Blood Pressure Fatigue Short leg/Orthotics Intestinal Problems Menopausal Symptoms

Check the following conditions that YOU have had. Circle conditions that are common to FAMILY MEMBERS.

- AIDS Alcoholism Cancer Diabetes Epilepsy Hyper/Hypothyroidism
- Heart Disease Lung Disease Scoliosis Stroke Ulcers Multiple Sclerosis

If you take prescription medications, please let us know the conditions for which you take the medication. (We do not need to know the name of the medication at this time.)

The Stress Test:

The following areas of stress can cause mis-aligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Physical/Emotional/Chemical Stress:

- Birth Trauma
- Car Accidents
- Physical Abuse
- Work Injuries
- Sleeping on Stomach
- Carrying Heavy Purse/Backpack/Child
- Driving for Many Hours
- Children Stress
- Relationship Stress
- Quick Tempered
- Poor Diet/Excessive Sugar
- Artificial Sweeteners
- Over-the-Counter Drugs (ex. Tylenol/Motrin)
- Slips/Falls
- Sports Injuries
- Poor Posture
- Sitting on a Wallet
- Extensive Computer Work
- Repetitive Lifting/Bending
- Continuous Hours Sitting/Standing
- Career Stress
- Concealed Feelings
- Smoker/Second Hand Smoke
- Caffeine
- Prescription Drugs

THERE IS A CHANCE I MAY CURRENTLY BE PREGNANT.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are a patient.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment. Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

- ◇Disclosures made to carry out treatment, payment and health care operations;
- ◇Disclosures made to you;
- ◇Disclosures made in our facility directory;
- ◇Disclosures made to individuals involved with your care;
- ◇Disclosures made for national security or intelligence purposes;
- ◇Disclosures made to correctional institutions or law enforcement officials; and
- ◇Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Gates Chiropractic
410 SE Fifth Street
Lees Summit MO 64063
Tel 816 525 1525

EFFECTIVE DATE OF NOTICE:
