PEAK CHIROPRACTIC

ID#:______________ Date:________

____WELCOME

PLEASE PRINT

First Name:_____________ M.I.:_____ Last Name: _________________Preferred Name:_________

Address:____________________________________City:__________State:_____ZipCode:_______

Birthdate:____/____/______Age:____Gender: M F Social Security #_____________________

Primary Phone:_________________ Cell Phone:________________Work Phone:______________

Home Email:________________________________ Work Email:______________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method: (circle one) Primary Phone Cell Phone Work Phone

Status: (circle one) Single Married Divorced Widowed Separated

Spouse's Name:_____________________ Multi-Racial: (circle one) Yes No Unknown

Race: (circle one) White Black/African American Hispanic or Latino I choose not to specify

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (circle one) English Spanish Other_______________

Occupation:___________________________ Employer:__________________

Emergency Contact: ___________________ Phone Number:_____________Relationship:_______

How were you referred to Peak Chiropractic? Patient___________ Physician__________

(circle one) Yellow pages Internet Radio Newspaper Sign Other______________

Have you ever been diagnosed with High Blood Pressure? (circle one) YES NO

Have you ever been diagnosed with Diabetes? (circle one) YES NO

Have you ever Smoked? (circle one) Never Smoked Former Smoker Currently Smoke

Staff Will Fill in: **Height:_________ Weight:_________ BP_____ /_____**

Pulse:______

List of current Medications, including dosage and frequency:

1______________________________ **6**______________________________

2______________________________ **7**______________________________

3______________________________ **8**______________________________

4______________________________ **9**______________________________

5______________________________ **10**_____________________________

List any known prescription drug allergies:

______________________________ ______________________________

______________________________ ______________________________

Surgeries and /or Hospitalizations (List and date)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

List any immunizations and date: (example Flu Vaccine)

______________________________ ________________________________

______________________________ ________________________________

List any family history : (such as Diabetes, High Blood Pressure, Kidney Disease, Stroke, Heart Disease, or Heart Failure)

__________________________________ _________________________________

__________________________________ _________________________________

__________________________________ __________________________________

Do you drink alcohol?: (circle one) None Casual Beer Wine Moderate Drinker Heavy Drinker

Do you drink Caffeine?: (circle one) None < 3 drinks/day 3-6 drinks/day > 6 drinks/day

Do you use recreational drugs?: (circle one) Yes No

Do you exercise?: (circle one) Never Daily Weekly Walk Run Swim Other________

Are you: (circle one) Employed Retired In School Un-Employed

If Retired, last occupation before Retiring________________________

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

_________________________________ ____________

Patient Name (please print) **Date**

____

Parent, Guardian or Patient Legal Representative

____

Signature

List below the names and relationship of people to whom you authorize the Practice to release Private Health Information:

___________________________ ______________________

___________________________ ______________________

___________________________ ______________________

___________________________ ______________________

PEAK CHIROPRACTIC

FINANCIAL:

Please understand payment of your bill is considered part of your treatment. We accept cash, check, Visa and Mastercard. We file Medicare. We are an out-of-network provider. We will provide you with the necessary information to file you own insurance. Non-covered services, such as X-rays and the initial exam fee are your responsibility. You are responsible for payment regardless of any insurance company determination of usual and customary rates. Parents (or guardians) are responsible for payment of treatment for a minor. For unaccompanied minors, payment arrangements must be made prior to treatment by calling the office. There will be a $25.00 charge for a missed appointment and/or cancellations with less than 24 hour notice.

I have read the Financial Policy, I understand and agree to this Policy. ____________________

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION:

There are several circumstances in which we may use or disclose your healthcare information.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of your services.
- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality purposes or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review this notice (164.520) before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change in our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of you health information, please let us know in writing. If we agree with your restrictions, the restriction is binding with us.

You may revoke your consent to us at any time. Your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read the consent policy and agree to its terms. I am acknowledgeing I have received a copy of this notice. I also acknowledge receipt of a copy of the office “Notice of Patient Privacy Policy”

HEALTHCARE INFORMATION AUTHORIZATION

Your chiropractors, Drs Greg and Melanie Hawthorne, and the members of their staff may need to use your name, address, phone number, and clinical records to contact you with an appointment reminder, information about treatment alternatives, ,or other health related information that may be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Information we use or disclose is based on authorization. If you do not five us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement of your care.

You may inspect or copy the information we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at anytime (164.524).

This notice is effective as of the date you sign it and will expire 6 (six) years after the date on which you last received treatment from us.

I authorize you to disclose my health information in the manner described above. I am also acknowledging I have received a copy of this authorization.

PATIENT NAME PRINTED ____________________________________

PATIENT SIGNATURE _______________________________________ DATE___________

AUTHORIZED PROVIDER REPRESENTATIVE _______________________

____ Individual refused to sign

____ Communication barriers prohibited obtaining acknowledgment

____ An emerging situation prevented us from obtaining acknowledgment