## **Notice of Privacy Practices Acknowledgement & Authorization**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy

regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Active Edge Chiropractic and Rehab Notice of Privacy Practices (NPP). I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. Patient Name (print) Patient's Date of Birth Date **Patient Signature** If signed by a personal representative or legal guardian: Name of Personal Representative: \_\_\_\_ Date Signature of Personal Representative: Relationship to Patient: \_\_\_\_\_ Drivers License Number: \_\_\_\_ State Signing the NPP Acknowledgement does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact. Office Use Only We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices: Attempt 1: \_\_\_\_\_\_Date \_\_\_\_\_Staff: \_\_\_\_

Attempt 2: \_\_\_\_\_\_\_Date \_\_\_\_\_\_Staff: \_\_\_\_\_\_

### PHI Use and Disclosure Authorization

## **PHI Use and Disclosure Authorization**

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Active Edge Chiropractic and Rehab disclosure of my individually identifiable health information to the individuals listed:

1.	Name Relationship	to Patient
Au	horization to:	
	Disclose treatment plans and test results	
	Billing information including statement balances	
	Past and future Appointments	
	Receive phone messages and/or email regarding appointments	or test results
	Other	
2.	Name Relationship	to Patient
Au	thorization to:	
	Disclose treatment plans and test results	
	Billing information including statement balances	
	Past and Future Appointments	
	Receive Phone Messages or email regarding appointments or to	est results
	Other	
We ha	ve permission to (please check all that apply):	
	Leave messages on home phone or with household members	
	Leave messages on work phone	
	Leave messages on cell phone	
	Confirm appointments by phone or text	
This au	thorization is effective through (check one):	
	//	
	NO EXPIRATION unless revoked or terminated by the patient of	or the patient's personal representative
Chirop that m	erstand that I may revoke this authorization to disclose information and Rehab in writing ( <i>Termination of Disclosure Form</i> provey revocation will not affect any actions taken by Active Edge Chilipsed in writing and processed.	vided on request). If I choose to do so, I am aware
Autho	rization to Disclose:	
Patien	t Name (print)	Patient's Date of Birth
Patien	t Signature	Date
Signat	ure of Personal Representative	Date
Relatio	onshin to Patient: Drivers License Nu	mber: State

# **CONFIDENTIAL HEALTH INFORMATION**

Active Edge Chiropractic/Rehab

1024 Maine Street
Quincy, Illinois 62301
Phone (217)222-6500
Fax (217)222-5688
activeedge1024@yahoo.com
y standards.

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)		Have you d	consulted a chiropractor befor	e? Patient N	Number (office use only)
Whom may we thank for refer	rina vou?	_ ONO O	es When?	If so, whom?	
Age Birth Date (MM/DD/YYYY)	Gender ○ Male ○ Female	O Nati		Asian O Black or African American	Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Decline to specify
				Smoking Status (age 13 and over)	
Your Last Name			ur Social Security Number	O Never A Smoker O Former Smoke O Current Every Day Smoker O Curr	Pr
Your First Name		You	ur Middle Name (or Initial)	O Heavy Smoker O Light Smoker	
Address				Marital Status  Married  Single  Divorced	
City	State	/Province	ZIP/Postal Code	○ Widowed ○ Separated Pref	erred Language
Home Phone	Cell F	Phone		Spouse's Name	
Email Address				Child's Name and Age	
Emergency Contact	Emer	gency Contact's	s Phone	Child's Name and Age	
Your Occupation		United States and Control of the Con		Child's Name and Age	8
Your Employer				Work Phone	- ž
Address				May we contact you at work?  ○ Yes ○ No	DEN
City	State	/Province	ZIP/Postal Code	Preferred method of contact?  O Home Phone O Cell Phone	CONFIDENTIAL
Primary Care Provider's Name	)			○ Work Phone ○ Email	Ħ.
Insurance Carrier			Policy Number		
Insured's Last Name			Birth Date (MM/DD/YYYY)	Who carries this policy?  Self Spouse Parent	Z Z
Insured's First Name	Insur	ed's Middle Na	me (or Initial)	·	OR.
Insured's Employer					INFORMATION
Address					
City	State	/Province	ZIP/Postal Code	Employer's Phone	PAGE 1/4

#### Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply. Location (Where does it hurt?) **Additional Complaint** Secondary Complaint Circle the area(s) on the **Primary Complaint** The additional symptom that prompted me to seek care The secondary symptom that prompted me to seek care illustration. The primary symptom that prompted me to seek care "0" for current condition today is: "X" for conditions experienced in the past And are the result of (darken circle): And are the result of (darken circle): And are the result of (darken circle): O An accident or injury O An accident or injury O An accident or injury ○ Work ○ Auto ○ Other \_\_\_ ○ Work ○ Auto ○ Other \_\_\_ ○ Work ○ Auto ○ Other \_\_\_ A worsening long-term problem A worsening long-term problem OA worsening long-term problem OAn interest in: O Wellness O Other \_ OAn interest in: O Wellness O Other \_\_\_\_\_ OAn interest in: O Wellness O Other \_\_\_\_ Onset (When did you first notice your current Onset (When did you first notice your current Onset (When did you first notice your current symptoms?) \_ symptoms?) symptoms?) \_ Prior interventions (What have you done to relieve Prior interventions (What have you done to relieve Prior interventions (What have you done to relieve the symptoms?) the symptoms?) the symptoms?) O Prescription medication O Acupuncture O Prescription medication O Acupuncture Chiropractic Over-the-counter drugs Chiropractic Chiropractic Over-the-counter drugs Over-the-counter drugs O Homeopathic remedies O Homeopathic remedies O Homeopathic remedies Olce O Physical therapy O Physical therapy Olce O Physical therapy Olæ ○ Heat O Heat O Surgery O Heat Surgery Surgery O Other \_\_\_\_\_ Other \_\_\_\_ Other \_\_\_\_ 1. What else should Active Edge Chiropractic/Rehab know about your current condition? 2. How does your current condition interfere with your: Work or career: Recreational activities: Household responsibilities: Personal relationships: 3. Review of Systems Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right. a. Musculoskeletal NONE () O Osteoporosis O O Neck pain O OArthritis O OScoliosis O OBack problems O O Hip disorders Initials \_\_\_\_ O Foot/ankle pain O Shoulder problems O Elbow/wrist pain O TMJ issues O Poor posture O Knee injuries b. Neurological NONE ( Had Have O Numbness Had Have Had Have O O Headache O Pins and O O Anxiety O O Depression Initials needles c. Cardiovascular NONE ( Had Have O O Poor circulation O O Angina O High cholesterol O Excessive O O Low blood Patient name bruisina toitiats pressure pressure d. Respiratory Had Have O Emphysema NONE ( Had Have O O Hay fever O O Pneumonia O O Asthma O O Apnea Patient Number Initials \_\_ (office use only) e. Digestive Had Have Had Have O Food sensitivities O O Heartburn NONE () Had Have O O Anorexia/bulimia O O Ulcer O O Constipation O O Diarrhea Doctor's Initials Initials 1. Sensory NONE () Active Edge Chiropractic/Rehab Had Have O O Loss of smell O O Loss of taste O O Blurred vision O O Ringing in ears O O Hearing loss O Chronic ear Initials infection NONE (

O O Hair loss

O O Skin cancer

O O Psoriasis

O O Eczema

O O Acre

O O Rash

0		Had Have		Have ○ OHypoglycemia	Had	Have O F	requent nfection		Swollen gland		Low energy	NONE O	Patient name
	enitourinary Have Sidney stones	Had Have	H	lad Have	Had	Have	rostate issues	Had	Have O Erectile	Had	Have O PMS symptoms	NONE	Patient Number
j. C	onstitutional		,				Coluito Ioodoo		dysfunction			Initials	(office use only)
О	Have ○ Fainting	Had Have		Have  ○ Poor appetite		Have F	atigue	О	Sudden weigh gain/loss (circle)	nt O	Have ○ Weakness	NONE O	All other systems negative
Past Please	Personal, Family a e identify your past he	and Social H alth history, in	story luding accide	ents, injuries, illnesses a	ınd trea	tments	. Please compl	ete ea	ch section fully.				
	4. Illnesses Check the illnesses y	usu baya <b>Uad</b>	n the next ar	Uaus saus			erations cal intervention	e ude			eatments the ones you've recei	and in the	
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7	O Glauco	ma C	O If Yes	please list:		00	Pacemaker Spine			00	O Herbs O Homeopat	hv	
PERSONAL	O O Gout					0	Shine			0		replacement	
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Hobbies:

	Citting	No Effect	Mild	Moderate Effect	Savere Effect	Grocery shopping ————	Ko Effect	Mild Effect	Moderate Effect	Severe Elfect	Patient name
Standing	=			_0_		, ,, ,	=				Patient Number
Walking	<u> </u>	_			_0		_	_			(office use only)
Lying down	-	_				• ,	_	_			
Bending over    Climbing stairs	•	_				•	-			<u> </u>	
Climbing stairs    Love life		-		_ 	$\subseteq$		_	_		<u> </u>	
Using a computer Getting to sleep Driving a car Concentrating Driving a car Concentrating Caring for family Yerd work  Exercising Own Mat is the major stressor in your life?  14. How much steep do you average per night? Hours  What is your preferred sleeping perition?  15. What is your preferred sleeping perition?  16. What is your preferred sleeping perition?  17. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals  18. What would be the most significant thing that you could do to improve your health?  19. In addition to the main reason for your visit today, what additional health goals do you have?  19. In addition to the main reason for your visit today, what additional health goals do you have?  19. In addition to the main reason for your visit today, what additional health goals do you have?  1 instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care outfered in this practice is based on the best available evidence and designed to reduce or correct vertebral sublustation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.  1 may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.  1 may request a capy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.  1 may request a capy of the Privacy Policy and understand it describes how my personal health information to the best of my knowledge larm not pregnant. Date of last menstrual period (MM/DD/YYYY):  1 grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health info	•	_	-			• •	_	-		<u> </u>	
Getting in/out of car							_	_	<u> </u>	<u> </u>	
Diving a car	- '					• •	_	_	_o_	<u> </u>	
Looking over shoulder	=									<u> </u>	
Caring for family	•	=				<u>-</u>	_	-		_o	
S. What is the major stressor in your life?	•	_				•	_	_		_o	
What is the type and approximate age of your mattress and pillow?							_	-		Houre	
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