

# 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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: \_\_\_\_\_  
(Print) 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 <i>Notice of Privacy Practices</i> :		
Attempt 1: _____	Date _____	Staff: _____
Attempt 2: _____	Date _____	Staff: _____

**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 \_\_\_\_\_

Authorization 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 \_\_\_\_\_

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and Future Appointments
- Receive Phone Messages or email regarding appointments or test results
- Other \_\_\_\_\_

We have 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 authorization is effective through (check one):

- \_\_\_/\_\_\_/\_\_\_
- NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Active Edge Chiropractic and Rehab in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Active Edge Chiropractic and Rehab until the termination request is received in writing and processed.

Authorization to Disclose:

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

Relationship to Patient: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_ 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  
website: aechiro.com

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 consulted a chiropractor before?

Patient Number (office use only)

No  Yes

Whom may we thank for referring you?

When?

If so, whom?

Age

Gender

Male  Female

Race

American Indian  Alaskan Native  Asian  Black or African American

Native Hawaiian  Other Pacific Islander  Other  White

Decline to answer

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker  Former Smoker

Current Every Day Smoker  Current Some Day Smoker

Heavy Smoker  Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status  Married

Single  Divorced

Widowed  Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone

Work Phone  Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

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Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Primary Complaint**

The primary symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

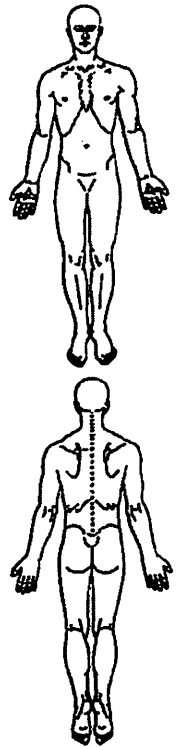
- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Location**  
 (Where does it hurt?)  
 Circle the area(s) on the illustration.  
 "O" for current condition  
 "X" for conditions experienced in the past



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**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis                   | <input type="radio"/> Arthritis                      | <input type="radio"/> Scoliosis                      | <input type="radio"/> Neck pain                      | <input type="radio"/> Back problems                  | <input type="radio"/> Hip disorders                  | Initials _____             |
| <input type="radio"/> Knee injuries                  | <input type="radio"/> Foot/ankle pain                | <input type="radio"/> Shoulder problems              | <input type="radio"/> Elbow/wrist pain               | <input type="radio"/> TMJ issues                     | <input type="radio"/> Poor posture                   |                            |

**b. Neurological**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety                        | <input type="radio"/> Depression                     | <input type="radio"/> Headache                       | <input type="radio"/> Dizziness                      | <input type="radio"/> Pins and needles               | <input type="radio"/> Numbness                       | Initials _____             |

**c. Cardiovascular**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure            | <input type="radio"/> Low blood pressure             | <input type="radio"/> High cholesterol               | <input type="radio"/> Poor circulation               | <input type="radio"/> Angina                         | <input type="radio"/> Excessive bruising             | Initials _____             |

**d. Respiratory**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma                         | <input type="radio"/> Apnea                          | <input type="radio"/> Emphysema                      | <input type="radio"/> Hay fever                      | <input type="radio"/> Shortness of breath            | <input type="radio"/> Pneumonia                      | Initials _____             |

**e. Digestive**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia               | <input type="radio"/> Ulcer                          | <input type="radio"/> Food sensitivities             | <input type="radio"/> Heartburn                      | <input type="radio"/> Constipation                   | <input type="radio"/> Diarrhea                       | Initials _____             |

**f. Sensory**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision                 | <input type="radio"/> Ringing in ears                | <input type="radio"/> Hearing loss                   | <input type="radio"/> Chronic ear infection          | <input type="radio"/> Loss of smell                  | <input type="radio"/> Loss of taste                  | Initials _____             |

**g. Skin**

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer                    | <input type="radio"/> Psoriasis                      | <input type="radio"/> Eczema                         | <input type="radio"/> Acne                           | <input type="radio"/> Hair loss                      | <input type="radio"/> Rash                           | Initials _____             |

\_\_\_\_\_  
**Patient name**

\_\_\_\_\_  
**Patient Number**  
 (office use only)

\_\_\_\_\_  
**Doctor's Initials**

\_\_\_\_\_  
**Active Edge Chiropractic/Rehab**



**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

13. What is the major stressor in your life? \_\_\_\_\_ 14. How much sleep do you average per night? \_\_\_\_\_ Hours

15. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 16. What is your preferred sleeping position? \_\_\_\_\_

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? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ I 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 offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials \_\_\_\_\_ I 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.

Initials \_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_

Initials \_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials \_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials \_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Consultation Notes

Doctor's Initials \_\_\_\_\_

Active Edge Chiropractic/Rehab

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)