ABBOTT FAMILY
CHIROPRACTIC

1620 S. Lawe St. Suite 2, Appleton, WI 54915
920-243-7140

Legal name: _____ Prefer to be called: _____
Date of birth: _____ /_____ /_____ Age: _____ M/F: _____ Occupation: _____
Home address: _____City: _____ State: _____ Zip: _____
Phone: (_____) _____ E-mail address: _____
In case of an emergency, please notify:_____ Phone:_____
Interested in appointment reminders? If yes, do you prefer _____ Email _____ Text
(Either option will be sent to you 2 hours prior to each appointment)
If text messages are preferred, which company provides your cell phone service: _____

Marital status: *Single Married Divorced Widowed Partnered* Name of spouse: _____
Names and ages of children: _____
How did you hear about us? Have you previously been to a chiropractor? *Yes No*

PLEASE READ: The purpose of today's visit is to see if chiropractic can help you. Your file will be carefully analyzed and you will receive a personalized report of findings.
The fee for today's examination is $129 (unless special arrangements have been previously discussed) and will be due today. If we feel chiropractic may help you and you choose to be adjusted today, the fee will be $35.

PLEASE INITIAL HERE indicating that you have read and understand this section: _____

Women (if pregnant):
How many weeks along are you? _____ Estimated Due Date: _____
How many times have you been pregnant? _____ Who is your OB/midwife? _____
What are your plans for birth? *Natural Vaginal with epidural Cesarean*
Planned location? *Home Birthing Center Hospital*
Have you had any ultrasounds? *Yes No* How many?_____
Health concerns for you or baby? _____

Reasons for visiting our office today:
□ No complaints, I'm here to use chiropractic care for my overall well-being.

1. _____ For how long? _____
How did it start? *Gradual Incident*: _____
Severity (0-10)? _____ What words would you use to describe it? _____
What makes it better? _____ What makes it worse? _____
What percentage of the day do you experience it? _____ Other providers you have seen for this?_____
2. _____ For how long? _____
How did it start? *Gradual Incident*: _____
Severity (0-10)? _____ What words would you use to describe it? _____
What makes it better? _____ What makes it worse? _____
What percentage of the day do you experience it? _____ Other providers you have seen for this?_____
3. _____ For how long? _____
How did it start? *Gradual Incident*: _____
Severity (0-10)? _____ What words would you use to describe it? _____
What makes it better? _____ What makes it worse? _____
What percentage of the day do you experience it? _____ Other providers you have seen for this?_____

Physical history:
Broken bones or major injuries:_____
Accidents or major trauma:_____
Sports throughout life: _____
Surgeries_____

Chemical history:
Medications:_____
Current medication/vaccination:_____
Tobacco / alcohol / other drug use:_____
Nutritional supplements:_____

Emotional history
Stress level (0-10):____Job satisfaction (0-10):____
Personal fulfillment (0-10):____ Professional development(0-10):____

Current and past body signals indicating underlying dysfunction: (Circle)

Abdominal pain
ADHD
Allergies
Amenorrhea
Anxiety
Asthma
Autoimmune disease
Back pain
Bedwetting
Blood disorder
Behavioral issues
Breastfeeding difficulties
Blurry vision
Cancer
Chest pain
Confusion
Constipation
Colic
Depression
Diabetes Type 1 2
Disc herniation
Difficulty swallowing
Digestion difficulties
Double vision
Ear infections
Excess stress
Excessive sweating
Fatigue
Fainting
Fibromyalgia
Frequent colds/flu
Headaches
Heartburn
High blood pressure
Incontinence
Infertility
Jaw pain/TMJ
Jaundice
Menstrual irregularity
Menstrual pain
Moody/irritable
Multiple Sclerosis
Nausea
Neck pain
Numbness/tingling
Pain with coughing, sneezing, straining
Pain:
- Shoulder
- Elbow
- Wrist
- Hand
- Hip
- Knee
- Ankle
- Foot

Persistent cough
Pubic symphysis dysfunction
Rash/redness
Rib pain
Ringing in ears
Sexual dysfunction
Seizures
Sinus problems
Sleep difficulties
- Falling asleep
- Staying asleep

Slurred speech
Tailbone pain
Torticollis
Weakness
Vision changes
Vomiting

How is your daily life (work, family, social) disrupted by your health? How does your health get in the way of your quality of life?

_____
_____
_____

Goals: What would you like to be able to do if your health was not a limiting factor?

_____
_____

I consent to a professional chiropractic evaluation examination deemed necessary by the doctor. I understand that any fee for services rendered is due at the time of service.

Signature: _____ Date: _____

Abbott Family Chiropractic, S.C.
INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but in this office instruments will be primarily utilized. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic care may include soreness or bruising. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidences does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative options have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE *ABBOTT FAMILY CHIROPRACTIC, S.C.* TO PROCEED WITH CHIROPRACTIC CARE.

DATED THIS _____ DAY OF _____, 20____

_____	_____	_____
Patient Signature	**Doctor Signature**	**Date**

Abbott Family Chiropractic, S.C.

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.

Our Legal Duty

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.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

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.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information,most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. 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 inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
Privacy Officer, Abbott Family Chiropractic, S.C., 2561 E. Calumet Street, Appleton, WI 54915

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Name of Personal Representative	Signature of Personal Representative	Date

_____
Legal Authority of Personal Representative

EFFECTIVE DATE OF NOTICE: