OPTIMAL MOVEMENT CHIROPRACTIC

Name_____Date _____
Address _____City _____ State ____Zip_____
Phone:(C)_____ (H)_____
E-mail_____
Date of Birth _____ (Age _____) Sex □ Male □ Female □ Other
Occupation_____

Family/Primary Physician_____ Phone_____
Emergency Contact_____ Phone_____ Relationship_____

How did you hear about us/who referred you? _____

Health History:_

Is this a Work Injury?	□ **Yes** □ **No**
- Have you reported the injury to your employer?	□ Yes □ No
Is this a Car Accident?	□ **Yes** □ **No**
- Has a police report been filed?	□ Yes □ No
- Have you lost any time from work as a result of your accident?	□ Yes □ No
Are you a Medicare Patient?	□ **Yes** □ **No**

Describe the reason for your visit today? _____
Date pain began? _____
Briefly describe what happened: _____
_____

How did your pain begin? □ Immediately after a specific event □ Multiple events
□ Gradually developed □ No apparent reason

What level would you rate your pain right now? None 0 1 2 3 4 5 6 7 8 9 10 Most severe
Is your pain: □ Constant (76-100%) □ Frequent (51-75%) □ Intermittent (26-50%) □ Occasional (0-25%)
Is your pain: □ Improving □ Worsening □ Not Changing
Have you had a similar problem before? □ Yes □ No
Is there anything that decreases your pain? _____
What increases your pain?_____
Is there anything else you feel might be related to this problem? _____
_____

Prior tests: X-ray, MRI, CT, ultrasound, lab,
other:_____
Prior treatment for this problem? □ None □ Physical Therapy □ Chiropractic
□ Acupuncture □ Massage □ Injections □ Surgery
□ Other _____

What have you been told is wrong?_____
When was treatment and did it work? _____

Family Medical History: Does anyone in your family have any of the following conditions?

□ Rheumatoid Arthritis □ Osteoarthritis □ Heart Disease □ Diabetes □ Muscle Disease □ Cancer □ Abnormal Bleeding

□ Other_____

Patient Medical History: Have you ever had any of the following conditions?

□ Cancer
□ Diabetes
□ Stroke
□ Seizures
□ Lung Disease
□ Arthritis
□ Osteoporosis
□ Joint Replacement
□ Other_____

□ Kidney disease
□ Thyroid Condition
□ Heart Condition
□ Pacemaker
□ High Blood Pressure
□ High cholesterol
□ Blood Thinners
□ Depression/Anxiety
□ Currently Pregnant

□ Ulcers
□ Anemia
□ AIDS/HIV
□ Tuberculosis
□ Glaucoma
□ Hepatitis
□ Alcoholism
□ Diverticulitis

Surgeries/Hospitalizations

_____Year_____
_____Year_____
_____Year_____
_____Year_____

Injuries/Fractures/Dislocations

_____Year_____
_____Year_____
_____Year_____
_____Year_____

Review of Systems: Please check any symptoms you have experienced in the past 6 months.

□ Unexplained weight loss
□ Unexplained weight gain
□ Head Trauma
□ Nausea/ Vomiting
□ Headache
□ Dizziness
□ Fainting
□ Night sweats
□ Difficulty sleeping
□ Immune system dysfunction
□ Burning on urination

NEUROLOGIC:
□ Tingling sensation
□ Weakness/ Numbness
□ Poor coordination
□ Loss of bowel/bladder control

LUNG:
□ Difficulty Breathing
□ Asthma
□ Wheezing

MUSCLE/BONE:
□ Joint pain
□ Arthritis
□ Bone Pain

VASCULAR:
□ Chest pain
□ Palpitations
□ Ankle Swelling
□ Leg cramps
□ High Blood Pressure
□ Poor circulation
□ Bruise easily

GI:
□ Gas
□ Heartburn
□ Abdominal Pain
□ Constipation
□ Diarrhea
□ Decreased urination

EYES:
□ Abrupt change in vision
□ Light sensitivity
□ Flashes in vision
□ Spots in Vision

EARS:
□ Abrupt change in hearing
□ Hearing difficulty
□ Earaches
□ Discharge
□ Ringing

NOSE:
□ Bleeds
□ Sinus problems

MOUTH:
□ Difficulty swallowing
□ Changes in taste
□ Bleeding gums
□ Jaw Pain

others: _____

Stress Level: Rate your stress level currently on a scale from 1-10 (10 being the most stress).
Overall stress:_____
Main reason for stress: _____
What steps are you currently taking to reduce your stress?_____
_____

Sleep Quality: How is your sleep? (check all that apply)
□ Restful □ Restless □ Hard to get sleep □ Wake up often □ Nightmares
Do you sleep on your □ Back □ Side □ Stomach
What time do you usually go to sleep? _____
Average hours of sleep night? _____

Energy Level: List on a scale from 1-10 (10 being the highest)
Overall: _____
what is your energy level during the following times:
AM: ____ Afternoon: ____ Evening: _____ Late PM :_____ After meals: _____

Daily Habits: For each of these items listed below specify if you consume them and how often i.e. 2 cups/day.
Coffee/Tea: _____ Soda: _____ Alcohol: _____ Water : _____
Fast food: _____ Tobacco: _____

Vitamins/Minerals: □ Multi □ Vit D □ Omega 3
_____

Medication: Please list current medications, duration, and reason for taking them:_____
_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named in this file, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Ryan Slaughter and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Ryan Slaughter and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of healthcare, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some “reaction” to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care(1):

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating Discomfort (10%) Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effect/complications

- Rib fracture
- Dislocations
- Disc Herniation

While Chiropractic adjustments have not been found to be associated with causing stroke or Cauda Equina Syndrome (permanent nerve damage), patients with these extremely rare conditions in process will present with neck and/or low back pain which leads them to seek chiropractic care.

I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

I have read the Informed Consent to Chiropractic Treatment document and I agree to its terms.

_____ _____

(Signature) **(Date)**

Description	CPT Code	Prompt payment Price	Delayed payment Price
Initial Exam	99203	$100	$145
Re-Exam	99214	$80	$124
Spinal adjustment (1-2 segments)	98940	$60	$45
Spinal adjustment(3-4 segments)	98941	$60	$55
Extremity adjustment	98943	Included	$40
Myofascial Release	97140	$40	$55
Therapeutic Exercise	97140	$40	$55
Neuromuscular Re-ed	97112	$40	$55
Rocktape (1-2 regions)	-	$10	$10
Rocktape (own tape)	-	$5	$5
Rocktape Roll	-	$20	$20
Rocktape band	-	$10	$10

Payment Agreement

I clearly understand and agree to the above payment agreement and am aware that if I fail to pay at the time of service, I understand and agree that I am financially responsible to pay the delayed payment price for any and all services rendered if my insurance does not cover any or all services at 100%.

_____ _____

(Signature) **(Date)**

Cancellation Policy

Appointments missed, or cancelled without providing 24 hours notice are subject to a $25 fee on the first occurance, $40 fee for the second occurrence, and then charged the full appointment price for any occurrence thereafter.

_____ _____

(Signature) **(Date)**

Insurance Coverage

With all insurance plans, there is usually a patient's responsibility for payment. This amount is either a deductible, a co-pay, or a coinsurance; Sometimes, your plan will require you to pay all three. We will contact your insurance company to determine what your responsibility is. It is illegal for a doctor's office to not collect the patient's responsibility. We will explain your responsibility clearly and in detail. If payment is required, we will help you choose the easiest method of payment.

In addition to patient responsibility, most insurances have a maximum number of visits they will allow as well as a maximum amount of payments per year. It is important to realize that these maximums are determined by the plan you choose, not by the amount of care needed to get healthy.

We will send your bills to your insurance company for the doctor's payment. Usually, the insurance company will send your payment for the service directly to our office. In some cases, the insurance company will make the payment to you in your name. Those checks need to be brought to our office as they are the doctor's payments.

If you would like to submit your bills to your insurance company on your own, you will need to pay for your treatment at the time of service at the Prompt payment price. At the end of the visit, you will be given a detailed Superbill that you can submit to your insurance company for reimbursement.

I understand that all upgrades or add-ons are not covered by insurance and that I must pay in full for these at the time of service.

I certify that I, and/or my dependent(s), assign all insurance benefits, if any, directly to Ryan Slaughter Chiropractic Corp. otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions; the above-named doctor/corporation may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits, or the benefits payable for related services. This consent will last as long as I continue care with Ryan Slaughter Chiropractic Corp.

_____ _____

(Signature) **(Date)**

Email Communication Release Form

I would like to communicate via email with Ryan Slaughter Chiropractic Corp and their staff on matters related to my health and/or my medical treatment. I understand that andy Confidential Health Information that I send to that practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via email.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via email. Because this information is not encrypted, I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

_____ _____

(Signature) **(Date)**

NOTICE OF PRIVACY PRACTICES (HIPPA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.
Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.
Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.
Others Involved in Your Health Care or Payment for your Care: 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 health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices

I, _____ have read and fully understand ALL the above statements. (Print name)

_____ _____

(Signature) **(Date)**