CHIROPRACTIC HISTORY

Date:__________________

Patient:_____________________________________

Address:____________________________________

____

Sex: M F Age:________ Birthday:_____________
❑Single ❑Married ❑Widow ❑Separated ❑Divorced
Number of Children:❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7+

Social Security #:_____________________________

Home Phone:_________________________________

Work Phone:_________________________________

Cell Phone:__________________________________

Occupation:_________________________________

Employer:___________________________________

Spouse's Name:______________________________

Birthday:___________ SS#_____________________

Who referred you to our office____________________

Height:______________ Weight:__________

INSURANCE:
Who is responsible for this account?

____

Relationship to the patient:

____

Insurance Co____
Patient covered by additional insurance❑Yes ❑ No
Subscribers Name:

____

Birthday:_____________ SS#______________________________

Relationship to patient:____________________________________

Group#_______________ Insurance Co______________________

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) Spouse's have insurance coverage with:

____

and assign directly to Dr. Morgan all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by Spouse's insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

_______________________________________ ____________
Relationship *Date*

X-Ray Authorization: I consent to any necessary diagnostic x-rays that the doctor deems beneficial to properly analyze and treat my case. I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am **NOT PREGNANT**, and I consent to x-rays.

Signature______________________________ Date__________

Reason for Visit:____

____

When did your symptoms appear?____
Is condition due to an accident? ❑Yes ❑No Date:___________
What is the cause?____

____

Is this condition getting progressively worse? ❑Yes ❑No
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain: ❑*Sharp* ❑*Stiffness* ❑*Numbness* ❑*Shooting* ❑*Burning* ❑*Throbbing*
❑*Aching* ❑*Tingling* ❑*Cramps* ❑*Dull* ❑*Other* ______________________________
Activities that are painful:❑*Sit* ❑*Standing* ❑*Walking* ❑*Bending* ❑*Lying Down* ❑*Work*
❑*Sleep* ❑*Daily Routine* ❑*Recreation* ❑*certain movements* ❑*coughing* ❑*driving*
Is the pain: ❑*constant* (75 to 100% of the time) ❑*frequent* (50 to 75% of the time)
❑*intermittent* (25 to 50%) ❑*occasional* (10 to 25%) ❑*rare* (less than 10% of the time)
Have you had: ❑*Back Surgery* ❑*Neck Surgery* ❑*Other spine surgery*
❑*Appendix removed* ❑*Gall bladder surgery* ❑*C-section* ❑*Hysterectomy*
Have you had any other surgeries in the past? ________________________________

____

What injuries, broken bones, falls, car accidents, etc. have you had in the past?

____

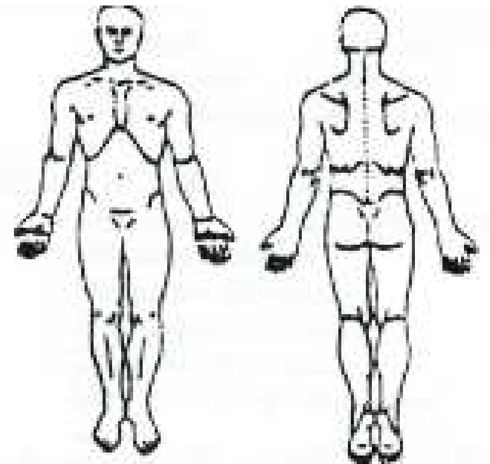
List any medications and/or diet supplements you are currently taking (what, side effects, frequency, etc.): ____

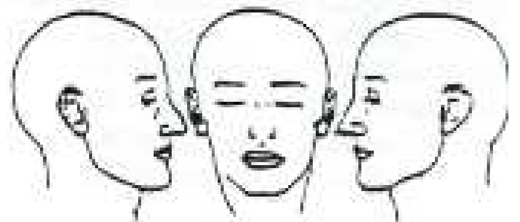
____

____

____

Mark the location of your pain below





Who is your General Practitioner (M.D.):
Name:___________________________________
Address:_________________________________

Do you speak: ❑English ❑Spanish ❑Other:___________________
Are you: ❑white ❑african-american ❑hispanic ❑other__________

Have you consulted any other doctors for this condition?

Name: ___________________________________ Name: ___________________________________
Address _________________________________ Address _________________________________

Which of the following illnesses have you had?

No Yes	No Yes	No Yes
N❑ Y❑AIDS/HIV	N❑ Y❑Tuberculosis	N❑ Y❑Sinus trouble
N❑ Y❑Asthma	N❑ Y❑Multiple Sclerosis	N❑ Y❑Diabetes
N❑ Y❑Epilepsy	N❑ Y❑Prostate trouble	N❑ Y❑High Blood pressure
N❑ Y❑Scoliosis	N❑ Y❑COPD	N❑ Y❑Sexually transmitted disease
N❑ Y❑Ulcer	N❑ Y❑Fibromyalgia	N❑ Y❑Low Blood pressure
N❑ Y❑Polio	N❑ Y❑Rheumatic fever	N❑ Y❑Mental/Emotional difficulty
N❑ Y❑Hepatitis	N❑ Y❑Kidney trouble	N❑ Y❑Thyroid trouble

N❑ Y❑Serious injury (please list): ______________________________
N❑ Y❑Dislocated joint (please list): ______________________________
N❑ Y❑Arthritis (please list): ______________________________
N❑ Y❑Bone fracture (please list): ______________________________
N❑ Y❑Cancer (please list): ______________________________
N❑ Y❑Heart trouble (please list): ______________________________
N❑ Y❑Allergies (medicine, stings, etc):______________________________
N❑ Y❑ANY disease or problem that can be passed from person to person

Other:

HABITS:

Smoking-❑Quit_________❑No ❑Occasional ❑Moderate
Alcohol- ❑No ❑Occasional ❑Moderate ❑Excessive
Exercise-❑Never ❑Occasional ❑3 times/Week ❑Daily
Coffee/Caffeine-❑No ❑Occasional ❑Daily ❑Several/day
Work Duties: ❑Sit ❑Stand ❑Light Labor ❑Heavy Labor

FAMILY HISTORY:

MOM:❑Diabetes ❑Heart Disease ❑High Blood Pressure
❑Cancer:______________________________

DAD:❑Diabetes ❑Heart Disease ❑High Blood Pressure
❑Cancer:______________________________

Please list any other history in your family of cancer, heart disease, diabetes, or other problem that runs in your family:
____
____
____
____

Are you presently suffering (or within the past six months suffered) from

GENERAL:
❑**Normal** ❑Fatigue
❑Weakness ❑Fever
❑Chills ❑Night sweats
❑Weight loss ❑Other ___________________

EYES:

❑**Normal**	***Right***	***Left***
Vision trouble	❑	❑
Pain	❑	❑
Discharge	❑	❑
Other	❑	❑_______________

NOSE:
❑**Normal** ❑Pain
❑Bleeding ❑Absence of smell
❑Other ______________________________

PSYCHOLOGIC:
❑**Normal** ❑Anxiety
❑Depression ❑Phobias
❑Mood Swings ❑Memory loss/impairment
❑Other ______________________________

GENITOURINARY:
❑**Normal** ❑Inability to hold urine
❑Painful urination
❑Frequent urination
❑Irregular Menstruation
❑Painful Menstruation
❑Abnormal vaginal bleeding
❑Other ______________________________

CARDIO-VASCULAR-PULMONARY:
❑**Normal** ❑Cough
❑Wheezing ❑Difficulty breathing
❑Murmur ❑Swollen extremities
❑Chest Pain ❑Blue extremities
❑Palpitations ❑Other ___________________

SKIN:
❑**Normal** ❑Rash
❑Redness ❑Itching
❑Eczema ❑Hair Changes
❑Nail changes ❑Other ___________________

EARS:

❑**Normal**	***Right***	***Left***
Hearing trouble	❑	❑
Ringing	❑	❑
Pain	❑	❑
Discharge	❑	❑
Other	❑	❑_______________

ENDOCRINE:
❑**Normal** ❑Heat/Cold intolerance
❑Sugar in urine ❑Goiter
❑Tremor ❑Other ___________________

NEUROLOGIC:
❑**Normal** ❑Headache
❑Dizziness ❑Fainting
❑Convulsions ❑Other ___________________

MOUTH/THROAT:
❑**Normal** ❑Bleeding
❑Sores ❑Absence of taste
❑Abnormal taste ❑Other ___________________

GASTROINTESTINAL:
❑**Normal** ❑Decreased appetite
❑Vomiting ❑Increased appetite
❑Diarrhea ❑Abdominal pain
❑Constipation ❑Other ___________________

BREAST:
❑**Normal** ❑Lumps in breast
❑Breast Pain ❑Breast redness/itching
❑Breast dimpling ❑Breast discharge
❑Other ______________________________

Morgan Chiropractic
Privacy Policy

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY!

Introduction:

Morgan Chiropractic is committed to giving you quality care and protecting your private health information. We are also committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 12/01/02.

Understanding Your Health Record/Information

Each time you visit Morgan Chiropractic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

*Basis for planning your care and treatment
*Means of communication among the many health professionals who contribute to your care
*Legal document describing the care you received
*Means by which you or a third party payer can verify that services billed were actually provided
*A tool in educating health professionals
*A source of data for medical research
*A source of information for public health officials charged with improving the health of this State and Nation
*A source of data for our planning and marketing
*A tool with which we can assess and continually work to improve the care we render and the outcome we achieve

Understanding what is in your record and how health information is used helps you to ensure it's accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of Morgan Chiropractic, the information belongs to you. You have the right to:

* Obtain a paper copy of this notice of information practices upon request
* Inspect and copy your health record as provided for by federal law (a reasonable fee may be charged to cover the costs of copying)
* Amend your health record as provided by federal law
* Obtain an accounting of disclosures of your health information as provided by federal law
* Request communication of your health information by alternative means or at alternative locations
* Request a restriction on certain uses and disclosures of your information as provided for by federal law
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Morgan Chiropractic is required to:

* Maintain the privacy of your health information
* Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain by you
* Abide by the terms of this notice
* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us with. Your responsibility is to notify us of address changes and insurance changes.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or To Report a Problem

If you have any questions or would like additional information, you may contact the practice's Privacy Officer, Laura Morgan or Dr. Tom Morgan at 256-332-4949.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Room 509 F HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Dr. Morgan and staff will record in your chart information obtained from each visit. That information is used to determine the course of treatment that works best for you. Dr. Morgan and staff will record what treatments were done, what symptoms were present, what prognosis what determined, what diagnosis was made, etc.

We will use your health information for payment.

For example: A bill may be sent to you or to a third party payer (like an insurance company, attorney, etc). The information being sent may include information that identifies you as well as your diagnosis and treatments.

We will use health information for regular health operations.

For example: Members of the staff, the risk or quality improvement manager may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contacts with associates. Examples include physician services in the emergency department, radiology, and certain lab test, referrals to other physicians, and others who may provide work in our office. We may need disclose your health information to our business associates so they may perform the job we have asked of them. We have an agreement with the business associates to protect your health information as well.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with Family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researches 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 health information.

Worker's Compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar established programs by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with law relating to worker's compensation or other programs. Your provider is required by law to report communicable diseases and certain conditions to the Center for Disease Control in Atlanta, Georgia. Your health information will be protected by our office and the CDC or health center.

Correctional Institution: Should you be an inmate of correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

MORGAN CHIROPRACTIC

Patient Consent For Use And/Or Disclosure of Protected Health Information
To Carry Out Treatment, Payment, and HealthCare Operations.

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1: *The Practice's Privacy Notice has been provided to me prior to signing this Consent.* The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully to signing this Consent.

2: The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3: I understand that, and consent to, the following appointment reminders or communications that will be used by the practice:

A.) *A postcard or letter mailed to me at the address provided by me.*
B.) *Telephoning my home and leaving a message on my answering machine or with an individual answering the phone.*

4: I understand that, and consent to, the following publications of my name for use in the practice newsletter mailed out to its patients: for birthdays and referrals.

5: I understand that, and consent to, the open treatment area for my treatment.

6: The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

7: I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, the restriction is binding on the Practice.

8: I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

9: I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

10: I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_________________________________ _________________________________

Name of Individual Signature of Individual

_________________________________ _________________________________

Signature of Legal Representative Relationship

_________________________________ _________________________________

Date Signed Witness