Springville Chiropractic

Print Patient's Full Name _____ Today's Date_____

Mailing Address _____

City _____ State_____Zip_____

Birth Date _____/_____/_____ Age_____ Male___ Female____ No. of Children _____

Home Phone ( ) _____ Cell Phone ( )_____

E-mail Address(If you would like to receive a newsletter, aprox once a month)_____.

Would you like further information about our other services? **(Help with health concerns such as Hypothryoidism, Fibromyalgia through Functional Medicine) Yes _____ No _____**

Name of Business/Employer _____Type of Work/Duties _____

Name of Spouse _____ ____Married ____ Single ____ Divorce ____Widowed ____Separated

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FOR PATIENTS UNDER AGE 18 (Please fill in information concerning responsible party)

Name of parent or guardian _____Place of employment _____

Home Phone _____Work Phone _____

Address _____ City _____State _____Zip _____

Who referred you to our office: _____Relative-Name _____

_____Friend-Name_____

_____Yellow Pages: ____ Dex _____ Provo/Orem Directory _____Other Book

_____Website / Internet

_____ Other _____

Health Insurance Co. Name _____Policy # _____

Is your name found on the insurance card? If not please print name and date of birth. (ie.your father or mother's name)

Name found on insurance card _____ Date of Birth _____

--Fill in if Applicable–

Auto Insurance Company _____

If Auto Accident, list the name of person whose name is on insurance policy _____

Current Health Condition

Please fill out each and every question, answer with N/A if it does not apply to you.

Main Health Complaint that brought you into this office _____

Any other doctors seen for this condition? Please list _____

List date this condition began _____

Medications you now take and reasons:_____

Brief history of significant injury (year and type of injury) _____

List year and type of surgeries _____

Previous chiropractic care? Yes ___ No ___ Chiropractor's name and date of last visit _____

What activities does your problem/complaint prevent you from doing that you would like to be able to do again?

_____

Use the following abbreviation of terms to indicate level of symptom severity, if no symptoms, leave space blank.
MI = mild Mo=Moderate S=Severe V=Severity Varies

Structural

_____ Headache
_____ Neck Pain
_____ Dizziness
_____ Jaw Pain
_____ Upper back pain (Between shoulders)
_____ Shoulder joint pain _____Rt. _____Lft.
_____ Elbow Pain _____Rt. _____Lft.
_____ Wrist or hand pain _____Rt. _____Lft.
_____ Pain-Numbness and/or tingling of: _____Rt. Lft._____ or _____Both

_____ Mid back pain
_____ Rib pain
_____ Low Back Pain
_____ Pain that shoots from low back to _____Rt. _____Lft.
_____Hip _____Upper leg
_____Lower leg _____Foot
_____ Numbness or tingling to _____Rt. _____Lft.
_____Hip _____Upper leg _____ foot

_____ Loss of strength anywhere?_____
_____ Knee pain _____Rt. _____Lft.
_____ Ankle pain _____Rt. _____Lft.
_____ Foot Pain _____Rt. _____Lft.
_____ Muscle Spasms? State where _____

PAYMENT IS DUE AT THE TIME OF SERVICE.
THERE WILL BE A $10.00 BILLING FEE FOR EACH MONTH OF DELINQUENT ACCOUNTS.

The practice of chiropractic, like all forms of health care, has known risks and although rarely include death, brain damage, quadriplegia, paraplegia, the loss of function for any organ or limb, or disfiguring scars associated with such care and treatment. To help determine contra-indications of care a thorough history and examination is routinely performed on all new patients and established patients when appropriate.

After printing form, sign here X_____
(Parent or Guardian if patient is a minor)

READ BELOW NOW, BUT DO NOT SIGN UNTIL THE DOCTOR HAS EXAMINED YOU
I have been informed of the nature and purpose of chiropractic care including possible risks of care. Alternative treatments have been explained and possible consequences if no care is provided. I understand the information provided and all questions I have asked have been answered to my satisfaction. I knowingly authorize to undergo chiropractic care and treatment.

SIGN HERE Patient Signature_____

Please check the appropriate response. If "Yes", please explain in the comments. If you are not sure, check the "?"
If "No", leave blank.

YES	?	
☐	☐	Do you have a past history of cancer?
☐	☐	Have you had any unexplained weight loss?
☐	☐	Does your pain improve with rest?
☐	☐	Are you over 50 years old?
☐	☐	Has your condition failed to respond to a course of conservative care (4-6 weeks)?
☐	☐	Have you had spinal pain greater than 4 weeks?
☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	Intravenous drug use?
☐	☐	Current or recent urinary tract, respiratory tract or other infections?
☐	☐	Immunosuppression medication and/or condition
☐	☐	History of significant trauma?
☐	☐	Minor trauma in person who is 50 years old or older?
☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	Are you over 70 years old?
☐	☐	Any history of prolonged use of corticosteroids?
☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear.
☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	Global or progressive muscle weakness in the legs (legs give out)?

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy is also available to you.

Springville Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required for administrative purposes, and to evaluate the quality of care that you receive.

Springville Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Springville Chiropractic may use your information to provide appointment reminders, thank-you cards and information about treatment alternatives or other health-related issues.

Springville Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function or in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health record, request communication of your information by alternative locations, revoke your authorization and request an accounting of your health records can be made to Dr. Olson.

You may complain to the Privacy Officer Richard Olson and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Springville, Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please call Dr. Richard Olson at 801-489-4990

_____ _____

Patient Signature (or Legal Guardian) Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Springville Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Springville Chiropractic.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Springville Chiropractic is not required to agree to the restrictions that I may request, however, if Springville Chiropractic agrees to a restriction that I request, the restriction is binding on me and Springville Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Springville Chiropractic or I have taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Springville Chiropractic's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Springville Chiropractic.
This Notice of Privacy Practices also describes my rights and the duties of Springville Chiropractic with respect to my protected health information.

The Notice of Privacy Practices for Springville Chiropractic is provided at 485 So Main Ste 101, Springville, Ut 84663

Springville Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____

Name of Patient or Personal Representative_____

Date_____

Description of Personal Representative's Authority_____