



**ADULT INTAKE PAPERWORK**

HELLO AND WELCOME TO ADDASU FAMILY CHIROPRACTIC!

Who may we thank for referring you / how did you hear about us? \_\_\_\_\_

Please fill out the following information and to the best of your ability.

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Preferred Name: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  
 E-mail: \_\_\_\_\_ Do you have insurance?  Yes  No  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Number of children and ages: \_\_\_\_\_  
 Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

Height: \_\_ ft \_\_ in Weight: \_\_\_ lbs Indicate if you have experienced the following:  
 What is your typical daily work activity?  Been unconscious due to an illness or injury  
 Sitting  Standing  Working at a Computer  Serious illness, operation, or health emergency  
 Manual Labor  Light Lifting  Heavy Lifting  Motor vehicle accident.  Fractured a bone  
 Driving  Other: \_\_\_\_\_ Explain (include year(s)): \_\_\_\_\_  
 List any over-the-counter/prescription drugs and vitamins/supplements that you are currently taking:  N/A \_\_\_\_\_  
 Do you have any genetic disorders or disabilities?  No  Yes *If yes, explain:* \_\_\_\_\_

**SOCIAL HISTORY**

**Do you smoke:**  Never  In the Past  Occasionally  Daily  
**Are you exposed to second hand smoke?**  Never  In the Past  Occasionally  Daily  
**Do you drink alcohol?**  Never  In the Past  Occasionally  Daily  
**Do you use recreational drugs?**  Never  In the Past  Occasionally  Daily  
**How often do you exercise?**  Never  In the Past  Occasionally  Daily

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes, how many times?** \_\_\_\_\_  
 When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_  
 Other forms of treatment tried:  No  Yes **If yes, please state what type of treatment:** \_\_\_\_\_  
 Who provided it? \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable  
 Please explain: \_\_\_\_\_  
 Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_  
 If you have ever been diagnosed with any of the following conditions, please indicate with:

**P** for in the **Past**      **C** for **Currently** have      **N** for **Never** have had

\_\_\_\_ Broken Bone    \_\_\_\_ Dislocations    \_\_\_\_ Tumors    \_\_\_\_ Rheumatoid Arthritis    \_\_\_\_ Fracture    \_\_\_\_ Disability    \_\_\_\_ Cancer  
 \_\_\_\_ Heart Attack    \_\_\_\_ Osteo Arthritis    \_\_\_\_ Diabetes    \_\_\_\_ Cerebral Vascular    \_\_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE IDENTIFY ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:  N/A

Injuries:  No  Yes Surgeries:  No  Yes Childhood Disease:  No  Yes Adult Diseases:  No  Yes

**If yes:** What was/is the injury, surgery or disease? \_\_\_\_\_  
 How long ago? \_\_\_\_\_ What type of care did you receive? \_\_\_\_\_ Provided by whom? \_\_\_\_\_

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant  I experience it on and off during the day  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes, when?** \_\_\_\_\_ **by whom?** \_\_\_\_\_

How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_

Name of previous chiropractor: \_\_\_\_\_  N/A

**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

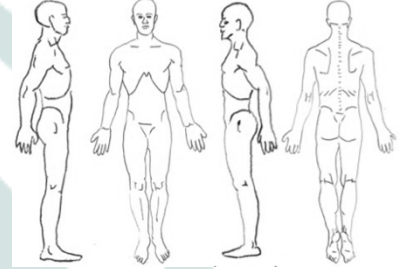
**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:



## FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)?  No  Yes **If yes, whom?**

grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)

Have they ever been treated for their condition?  No  Yes  I don't know

Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

## CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are your health and lifestyle goals you hope to achieve while under chiropractic care?

**PLEASE CHECK ALL THAT APPLY:**

Decrease the severity & intensity of my pain/problem(s)

Decrease the frequency of my pain/problem(s) (how often the pain/problem(s))

By the end of my corrective chiropractic care, I hope to be able to \_\_\_\_\_

I hereby authorize payment to be made directly to Addasu Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Addasu Family Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

## ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity	No Effect	Minimal Pain (can do)	Significant Pain (limited activity)	Unable to Perform	N/A
Bath/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groom Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily Physical Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seat to Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go Up/Down Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get In/Out of Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focus/Concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House Hold Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry Bag/Purse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run/Hike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

## REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently have or have had in the past. (Adopted?  No  Yes)

Condition	Current	Past	Never	Family (if applicable) Circle: Child/Sibling/Parent/Grandparent
Acid Reflux/Heartburn/GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Arthritis/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Asthma/Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Ear Problems/Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Frequent Illness (Cold/Flu/ect.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Menstrual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Mood Changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Pain Coughing or Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Pregnancy (Now)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Sinus/Drainage Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Swelling of Legs/Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
TMJ/Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Trouble Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G
Organic/System Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C/S/P/G

**If checked select ALL that apply:**  Digestive  Gallbladder  Liver  Stomach  Pancreas  Colon  Reproductive  
 Lung/Respiratory  Heart  Urinary  Kidney  Prostate  Vision  Thyroid  Skin  Sexual  
 Other(s): \_\_\_\_\_ Explain: \_\_\_\_\_

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

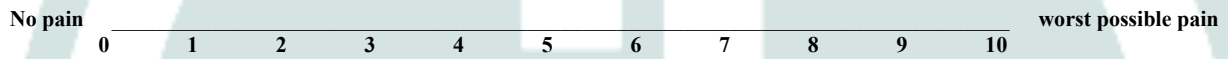
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

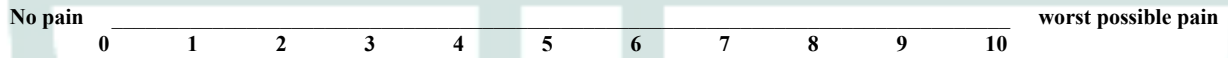
**Example:**



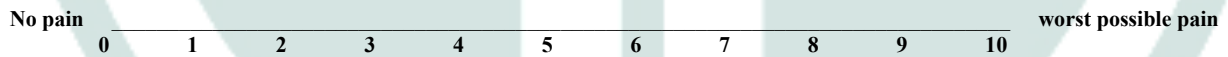
**1 – What is your pain RIGHT NOW?**



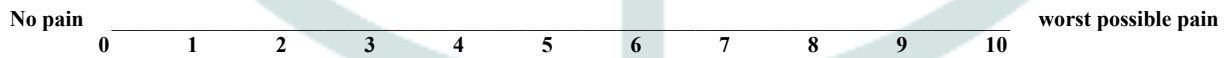
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

## INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Addasu Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

## AUTHORIZATION FOR X-RAYS

**FEMALES ONLY:** Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.

The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

**Male & Female:** By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

## HIPPA PERSONAL HEALTH INFORMATION RELEASE

I, \_\_\_\_\_, hereby authorize Addasu Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse Name: \_\_\_\_\_
- Significant Other Name: \_\_\_\_\_
- Parent/Legal Guardian Name: \_\_\_\_\_
- Child(ren) Name(s): \_\_\_\_\_
- Any Specified Person Name: \_\_\_\_\_
- Information is not to be discussed with or released to anyone.

### Restrictions:

- No Restrictions  Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

### Messages:

Please call  my home  my work  my cell phone Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

If unable to reach me:

- you may leave a detailed message  please leave a message asking me to return your call
- \_\_\_\_\_

I understand I may terminate this consent at any time by giving written notice to Addasu Family Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

### YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

### USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

**COMPLAINT:** If you wish to make a complaint about how we handle your health information, please contact our Dr. Kevin G. Powell at [drkpowell@addasufamilychiropractic](mailto:drkpowell@addasufamilychiropractic) OR call (615) 590-9618. If Dr. Powell is unavailable, you may make an appoint with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: U.S. Dept. of Health and Human Services, Office of Civil Rights | 200 Independence Avenue, SW, Washington DC 20201 | 877-696-6775 | [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

\_\_\_\_\_  
**Patient or Authorized Person’s Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor’s Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

## ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (CONTINUED)

I hereby acknowledge I have read and received a copy of Addasu Family Chiropractic Privacy Practices Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice. I am aware an extended detail version of this "Notice" is available to me upon request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- \_\_\_\_\_ Parent or guardian of minor patient
- \_\_\_\_\_ Guardian or conservator of an incompetent patient
- \_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

### For Office Use Only

Signed form received by: \_\_\_\_\_

Reason acknowledgment not obtained: \_\_\_\_\_

Efforts to obtain: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_