Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/Student Permanent Addresses _____

_____

Employer/Student Permanent Hm. Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, 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 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 end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

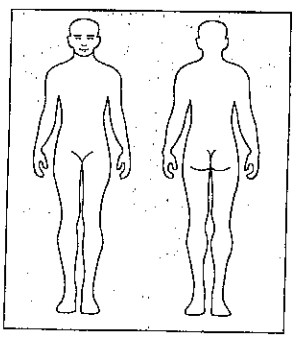
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	_____
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No				
		Measles	☐ Yes ☐ No				

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (____) _____

Allergies

_____
_____
_____
_____
_____

Vitamins/Herbs/Minerals

_____
_____
_____
_____
_____

Effective Date of This Notice: April 15, 2003

DR. CAMPBELL'S OFFICE POLICY

Patient Name _____

OFFICE: We believe that a clear definition of our office policies will allow us to concentrate on "The Big Issue" REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of our office to provide you with the finest quality of chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know.

Initials____ NOTICE OF RECEIPT OF PRIVACY NOTICE: By signing this I had acknowledged that I have received and reviewed the privacy notice Advanced Chiropractic, PC. In force as of April 14th, 2003.

Initials____ PHONE CONTACT: Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, follow through medical information, treatment alternatives, payment arrangements and/or delinquent accounts, or other health related information. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By initialing, you are giving us authorization to contact you and to leave messages on your answering machine or with individuals at your home or place of employment.

Initials____ INFORMED CONSENT: The patient has been informed and understands that the practice of chiropractic includes treatment by manipulation of the patient's body, including the spine. Manipulation of the body and the spine necessarily involves applying pressure, by the use of "hands-on" techniques which require Dr. Campbell to use his hands and body to cause appropriate movement within the patient's body. Manipulation by a chiropractor should not cause damage to the patient.
Manipulation of the patient by the chiropractor will necessarily involve physical contact between Dr. Campbell and the patient. The patient acknowledges that the general nature of this physical contact has been explained to them by Dr. Campbell prior to commencement of treatment and examination. During treatment, Dr. Campbell may touch the patient's body in a variety of areas including near the patient's groin, buttock, and near the patient's breasts. If the patient feels that such potential for contact may be distressing or uncomfortable, the patient should either avoid chiropractic treatment with this chiropractor or, in writing request that an attendant observer be present during treatment and examination, subject to any applicable charge.
If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs, you will immediately inform Dr. Campbell and give him sufficient notice to allow him to alter the treatment plan as appropriate.

Initials____ THANK YOU CARDS: When you refer a friend, family member or colleague to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a thank you card.

Initials____ FINANCIAL ARRANGEMENTS: We have an open front desk and many of our financial arrangements are discussed at the front counter. Please do not initial this if you would prefer to have your financial arrangements discussed in a more private place.

Initials____ MASSAGE THERAPY CANCELLATION POLICY: We ask that you arrive at least **10 minutes** before your scheduled appointment time in order to ensure a full massage session. Our cancellation policy is as follows: You may cancel your appointment **without charge** anytime before the close of business on the business day **preceding** your appointment. Same day cancellations will be **charged 50%** of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be **charged full price** for the scheduled service.

Initials____ CELL PHONE POLICY: We respectfully ask that you have your cell phone **turned off** or put on **silent mode**. Our goal is to provide a relaxing environment for our patients. Please initial for our cell phone policy verifying you will comply.

I have read and fully understand all of the above information. I acknowledge that I have read or received a copy of Dr. Campbell's Notice of Office Practices. I also understand that my refusing to sign this form means that I will not be treated at this office.

Patient's Signature_____ Date_____

Guardian's Signature Authorizing Care of Minor_____

Effective Date of this Notice: April 15, 2003

Notice of Privacy Practices

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Advanced Chiropractic Center, P.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at the office, please contact the office at (405)743-4340

I. How Advanced Chiropractic Center, P.C. may use or disclose your health information

Advanced Chiropractic Center, P.C. collects health information from you and stores it on a computer. This is your medical record. The medical record is the property of Advanced Chiropractic Center, P.C., but the information in the medical record belongs to you. Advanced Chiropractic Center, P.C. protects the privacy of your health information. The law permits Advanced Chiropractic Center, P.C. to use or disclose your health information for the following purposes:

1. Treatment. We may disclose information regarding your treatment to other health care providers who have requested information pertaining to your treatment.
2. Payment. In the event that your health insurance company should need specific information regarding your health care in order to issue payment, we will provide the information to the entity issuing the request.
3. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
4. Required by law. As required by law, we may use and disclose your health information.
5. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
6. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
7. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
8. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
9. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
10. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
11. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.
13. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services.
14. Change of ownership. In the event that Advanced Chiropractic Center, P.C. is sold or merged with another organization, your health information/records will become the property of the new owner.

II. When Advanced Chiropractic, P.C. May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Advanced Chiropractic Center, P.C. will not use or disclose your health information without your written authorization. If you do not authorize Advanced Chiropractic Center, P.C. to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Advanced Chiropractic Center, P.C. is required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative me3ans or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that Advanced Chiropractic Center, P.C. amend your health information that is incorrect or incomplete. Advanced Chiropractic Center, P.C. is not required to change your health information and will provide you with information about Advanced Chiropractic Center, P.C. denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by Advanced Chiropractic Center, P.C., except that Advanced Chiropractic Center, P.C. does not have to account for the disclosures described in parts 1 (treatment) and 2 (payment) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

IV. Changes to this Notice of Privacy Practices

Advanced Chiropractic Center, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Advanced Chiropractic Center, P.C. is required by law to comply with this Notice. In the event that this Notice is changed, a copy of the revised version will be mailed to the address we have on file.

V. Complaints

Complaints about this Notice of Privacy Practices or how Advanced Chiropractic Center, P.C. handles your health information should be directed to Advanced Chiropractic, P.C. 206 S Main Street, Suite B, Stillwater, OK 74074

If you and not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr.regmail.html