

WELCOME TO GATES CHIROPRACTIC

Name:	Today's Date:	
Nick Name:		
Mailing Address:	City:	Zip:
Home Phone:	Work Phone:	Cell:
Email Address:		
Birth Date:	Age:	Social Security #:
How did you learn about our office?		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Spouse's Name:		
Name and Ages of Children:		
Patient's Employer/Business:		
Occupation:		
Recent Work-Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No Approximate Last Visit Date:		

[Please check reasons for pursuing chiropractic care:](#)

- I'm continuing ongoing care from another chiropractor.
- I'm interested in wellness and natural health care.
- I'm concerned about my health and I'm looking for answers.
- I have a specific condition that concerns me.

Explain condition or symptom:

- I want to improve my immune function.
- I have no idea why I'm here. Please take the time to explain to me what you do.

Consent for minor child. Guardian/Parent Signature: _____

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

- | | | | | |
|--|---------------------------------------|--|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> Postural Imbalance | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Allergy/Sinus |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Short leg/Orthotics | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Menopausal Symptoms |

Check the following conditions that YOU have had. Circle conditions that are common to FAMILY MEMBERS.

- | | | | | | |
|--|---------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hyper/Hypothyroidism |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Multiple Sclerosis |

If you take prescription medications, please let us know the conditions for which you take the medication. (We do not need to know the name of the medication at this time.)

The Stress Test:

The following areas of stress can cause subluxated vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Physical/Emotional/Chemical Stress:

- | | |
|--|--|
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Slips/Falls |
| <input type="checkbox"/> Car Accidents | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Work Injuries | <input type="checkbox"/> Sitting on a Wallet |
| <input type="checkbox"/> Sleeping on Stomach | <input type="checkbox"/> Extensive Computer Work |
| <input type="checkbox"/> Carrying Heavy Purse/Backpack/Child | <input type="checkbox"/> Repetitive Lifting/Bending |
| <input type="checkbox"/> Driving for Many Hours | <input type="checkbox"/> Continuous Hours Sitting/Standing |
| <input type="checkbox"/> Children Stress | <input type="checkbox"/> Career Stress |
| <input type="checkbox"/> Relationship Stress | <input type="checkbox"/> Concealed Feelings |
| <input type="checkbox"/> Quick Tempered | <input type="checkbox"/> Smoker/Second Hand Smoke |
| <input type="checkbox"/> Poor Diet/Excessive Sugar | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Prescription Drugs |
| <input type="checkbox"/> Over-the-Counter Drugs (ex. Tylenol/Motrin) | |

THERE IS A CHANCE I MAY CURRENTLY BE PREGNANT.

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (the spine) and function (the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Disclosures:

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- I have received a copy of the Notice of Privacy Practices for Protected Health Information.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. Gates Chiropractic does not accept assignment of insurance benefits, but will provide all documentation for me to use in filing claims with my insurance company.
- If my case is accepted by Gates Chiropractic, chiropractic adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.
- I consent to have my spouse/significant other present during my report of findings.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Medicare Patients:

Patient's or Authorized Person's Signature-I authorize the release of any medical or other information necessary to Medicare. I also request payment of government benefits to myself or to the party who accepts assignment below. I am aware that Medicare may deny coverage of care and I agree to pay for services not covered by Medicare.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are a patient.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION

II. Your Rights

RIGHT TO REQUEST RESTRICTIONS. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

RIGHT TO INSPECT AND/OR COPY. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

RIGHT TO AMEND. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment. RIGHT TO RECEIVE AN ACCOUNTING. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

- ◇Disclosures made to carry out treatment, payment and health care operations;
- ◇Disclosures made to you;
- ◇Disclosures made in our facility directory;
- ◇Disclosures made to individuals involved with your care;
- ◇Disclosures made for national security or intelligence purposes;
- ◇Disclosures made to correctional institutions or law enforcement officials; and
- ◇Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

RIGHT TO RECEIVE NOTICE. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Gates Chiropractic & 410 SE Fifth Street Lees Summit MO 64063
Tel 816 5251525 & Email: drjackiedc@att.net

Signature

Date