CARTER FAMILY CHIROPRACTIC

Dr. Lauren Carter & Dr. Steven Carter
101 West College, Suite 2
Troy, MO 63379
636.775.2500

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth:_____ Sex: □ Male □ Female Marital Status: □ Single □ Married □ Minor

What name do you prefer to be called? _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address_____

Please indicate the best time of day to contact you:_____

We utilize text and email for appointment reminders and agreed upon communication with the doctor and front desk.

Appointment text reminders are sent the day before your appointment.

Do you consent to receive communication via text and email? Y / N

How did you hear about the doctor: _____

Employer: _____ Occupation: _____

Emergency Contact Name and Number: _____

Responsible Party: *Indicate who is responsible for charges related to the patient's care.*

Name of person responsible for this account: _____

Relationship to patient: _____ DOB: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

YOUR HEALTH PROFILE

	Yes	No	Unsure	Comments
Do you drink water daily?	□	□	□	How much:_____
Do you drink caffeine?	□	□	□	How much:_____
Do/did you smoke?	□	□	□	How much:_____
Do/did you drink alcohol?	□	□	□	How much:_____
Do you take any supplements?	□	□	□	What kind/which:_____
Do/did you play any adult sports?	□	□	□	Which:_____
Do you exercise regularly?	□	□	□	Type:_____

Do you sleep on your back / front / side (circle all that apply)

On a scale of 0 – 10 describe your stress level (0 = none / 10 = extreme) Occupational _____ Personal _____

On a scale of Poor / Good / Excellent please describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____ Mental State _____

Please share any preferences you would like the doctor to be aware of

_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Please briefly describe your chief complaint:_____

When did you first notice the symptoms?_____

What are these symptoms preventing you from doing?_____

Do your symptoms interfere with: □Work □Sleep □Walking □Sitting □Bending □Lifting

If you are experiencing pain, is it: □Sharp □Dull □Comes and Goes □Travels □Constant

Since the problem started, it is: □About the Same □Getting Better □Getting Worse

What makes it worse? And better, if anything?_____

Other Doctors seen for this problem (please list):_____

CHECK THE HEALTH SYMPTOMS WHICH HAVE OCCURRED:

□AIDS/HIV	□Emphysema	□Migraine Headaches	□Scarlet Fever
□Alcoholism	□Epilepsy	□Miscarriage	□Skin Problem
□Allergy Shots	□Fractures	□Mono	□Stroke
□Anemia	□Gout	□Multiple Sclerosis	□Suicide Attempt
□Appendicitis	□Hearing Problems	□Mumps	□Thyroid Disorder
□Arthritis	□Heart Disease	□Osteoporosis	□Tonsillitis
□Asthma	□Hepatitis	□Pacemaker	□Tuberculosis
□Bleeding Disorders	□Hernia	□Parkinson's Disease	□Tumors/Growths
□Tissue Lumps	□Herniated Disc	□Pinched Nerve	□Typhoid Fever
□Bronchitis	□High Cholesterol	□Pneumonia	□Ulcers
□Cancer	□High Blood Pressure	□Polio	□Venereal Disease
□Chemical Dependency	□Infertility	□Prostate Problem	□Vision/Eye Problem
□Chicken Pox	□Kidney Disease	□Prostheses	□Whooping Cough
□Depression	□Liver Disease	□Psychiatric Care	□Other (please list)
□Diabetes	□Lung Disorder	□Rheumatic Fever	_____
□Eating Disorders	□Measles	□Rheumatoid Arthritis	_____

□Surgical History: _____

Please circle the number to select the most appropriate statement. 0 = Able to function / 10 = Unable to function

Family/Home Responsibilities (chores, duties around the house): 0 1 2 3 4 5 6 7 8 9 10

Recreation/Social Activity (hobbies, sports, social functions): 0 1 2 3 4 5 6 7 8 9 10

Occupation (activities directly related to one's job): 0 1 2 3 4 5 6 7 8 9 10

Self Care (personal maintenance and independent daily living): 0 1 2 3 4 5 6 7 8 9 10

Women: Are you pregnant? □Yes □No Taking birth control pills? □Yes □No

List any medications you are currently taking:_____

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns for your: Children: _____

Spouse/Partner/Significant Other: _____

Parents/Siblings: _____

The statements made on this form are accurate to the best of my knowledge.

_____ _____

Signature Date

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Terms of Acceptance/Consent to Treat
When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective. Chiropractic has only one goal. 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 and disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of Vertebral Subluxation.

Potential Risks: The risk of injury or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprain/strain, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, and dislocations.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I,_____, have read and fully understand the above statement. I have also had the opportunity to ask questions and all of the questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek.

Patient Signature_____ Date_____

Consent to evaluate and adjust a minor child (for treatment of a child less than 18 years).

I,_____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grand permission for my child to receive chiropractic care.

Parent Signature_____ Date_____

POLICIES
All payments are due when services are rendered unless other arrangements have been made.

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. I understand Dr. Carter's will prepare all necessary reports and forms to assist in making collections from the insurance company and that any amount authorized be paid directly to Dr. Carter's will be credited my account upon receipts. However, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if action becomes necessary to collect on this account.
Patient Signature_____ Date_____
Guardian Signature Authorizing Care_____ Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

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.

The following is the privacy policy ("Privacy Policy") of Carter Family Chiropractic, as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Treatment: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Payment: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law: We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or

problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

Miscellaneous Activities, Notice: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information
Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure: You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications: You have the right to receive confidential communications of your personal health information.

Right To Inspect And Copy Your Personal Health Information: Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests.

Right To Amend Your Personal Health Information: You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information
Amendments to this Privacy Policy**:** We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

Signature below is acknowledgement that you have received this Notice of Privacy Practices:Print Name:_____
Signature:_____Date:_____