New Patient Application for Care

Welcome to **Reyes Active Body Chiropractic!** Please complete ALL questions.

NAME: ____Date: ________________

ADDRESS: ____

CITY/STATE/ZIP ___________________________EMAIL: ____________________________

PHONE: **Home** ____________________ **Cell** ____________________**Work** ________________

DATE OF BIRTH: __________AGE: _____ Referred by: ____________________________

YOUR OCCUPATION: ____________________ Employer: ____________________________

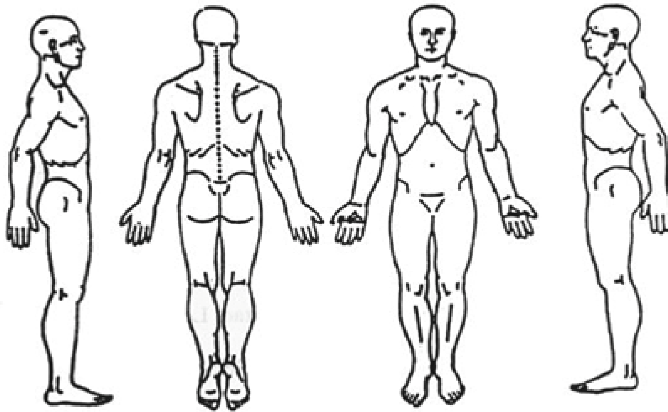
Marital status: M/W/D/S Spouse's name: __________________________ Children: Y/N

Previous Doctor of Chiropractic: ____

Health reasons for consulting our office today:

1. 2.

3. 4.



Have you had the same/similar problems in the past? Y/N Explain:

____

____

Other doctors consulted for this problem (Name and phone#)

____

Father/Mother/Brother/Sister/Children with similar problems?

____

____

Other methods used to alleviate pain/problem: ______________________________

____

Major accidents/traumas: ____

Fractures/Dislocations: ____

ANY Surgery you have had: ____

Are you under emotional stress: Y/N
Do you have sufficient energy for daily activities? Y/N

Medications, supplements, vitamins you currently take:

____

____

What have you heard about Chiropractic care?

____

Do you know what a subluxation is? If yes, please describe

____

After completing this application, please present your insurance card to our front desk chiropractic assistant.

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement of my well-being.

***Patient/Guardian Signature:* ______________________________ *Date:* ____/____/____**

Broken Bones ______________________ ________

Dislocations ______________________ ________

Surgeries ______________________ ________

Review of Systems - Have you ever had any of the following?

Cardiovascular
- ☐ No to all
- ☐ Poor Circulation
- ☐ High Blood Pressure
- ☐ Aortic Aneurysm
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Pace Maker

Respiratory
- ☐ No to all
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cold/Flu
- ☐ Cough/Wheezing
- ☐ Sputum
- ☐ Coughing Blood

Musculoskeletal
- ☐ No to all
- ☐ Gout
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Joint Replacement
- ☐ Disc Herniation
- ☐ Hernia

Allergic/Immunologic
- ☐ No to all
- ☐ Hives
- ☐ Immune Disorder
- ☐ HIV/AIDS
- ☐ Allergy Shots
- ☐ Cortisone Use

Neurological
- ☐ No to all
- ☐ Stroke
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Brain Aneurysm
- ☐ Numbness
- ☐ Pinched Nerves
- ☐ Carpal Tunnel
- ☐ Balance Problems

Head
- ☐ No to all
- ☐ Headaches
- ☐ Severe Headaches
- ☐ Migraines
- ☐ Head Injury

Skin
- ☐ No to all
- ☐ Skin Lesions
- ☐ Skin Ulcers
- ☐ Skin Disease/Cancer
- ☐ Eczema
- ☐ Psoriasis

Gastrointestinal
- ☐ No to all
- ☐ Gallbladder Problems
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Liver Problems/Disease
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Bloody Stools

Genitounrinary
- ☐ No to all
- ☐ Kidney Disease
- ☐ Lower Side Pain
- ☐ Burning Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Kidney Stones

Hematologic/Lymphatic
- ☐ No to all
- ☐ Hepatitis
- ☐ Blood Clots
- ☐ Cancer
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Fevers/Chills/Sweats

Endocrine
- ☐ No to all
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Hair Loss
- ☐ Menopausal
- ☐ Menstrual Problems

Psychiatric
- ☐ No to all
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Eating Disorder
- ☐ Unusual Stress

Ears/Nose/Throat
- ☐ No to all
- ☐ Hearing Loss
- ☐ Sinus Infection
- ☐ Nosebleed
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Bleeding Gums

Eyes
- ☐ No to all
- ☐ Glaucoma
- ☐ Double Vision
- ☐ Blurred Vision

General
- ☐ No to all
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Energy Level Problem
- ☐ Anemia
- ☐ Difficulty Sleeping

I acknowledge that all information and answers given on this form are accurate to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my health or health condition.

Patient signature: ______________________________ Date: ____________

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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes:

Treatment, payment, and health care options.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes physical examination, scheduling other exams or appointments with other providers, physician-to-physician discussion for coordination of care, and physician-to-staff for coordination of care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our own practice on a daily basis. The functions include, the entire staff having access to your file to obtain authorization of medical procedures, filing paperwork, recording phone messages or vitals from your visit, confirming your appointment with our office, scheduling your appointment with our office, obtaining the medical complaint for your visit and dictating notes to an outside source of your visit.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any given time. You will then be required to review and resign acknowledging the changes and consenting to the changes.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures of family members, other relatives, close personal friends, or
- any other person identified by you.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected information.
- The right to receive accounting of disclosure of protected health information.
- The right to receive a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 1, 2008, and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have the recourse if you feel that your privacy protections have been violated.

You have the right to file a formal complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of this office.

Please contact us for more information, by asking to speak to our Privacy Officer at (703) 753-0974. For written inquires, note "Attention Privacy Officer" at 14535 John Marshall Highway Suite 203, Gainesville, VA 20155.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in my treatment indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but, if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except if you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ________________________________ Date: __________

Relationship to Patient: ________________________

Consent to Treat

Patient's Name: ____

I have been informed of the nature of my disorder(s) and of the nature and purpose of Chiropractic/Physical Therapy procedures proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternate treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.

I have read the above paragraph and I understand the information provided. This information has been explained to me, and all the questions which I have asked have been answered to my satisfaction. I therefore authorize this clinic to proceed with Chiropractic and Physical Therapy care and treatment.

Patient's Signature: ________________________________ Date: ____________

Provider's Signature: ________________________________ Date: ____________

Please complete the following if the patient is *a minor or unable to consent.*

Patient's Name: ____________________________________

Patient's Age: __________

Name of person legally authorized to sign for this patient: ______________________
Relationship: ____________

Signature of authorized person: ________________________ Date: ____________

Provider's Signature: ________________________________ Date: ____________

Reyes Active Body Chiropractic No-Show/Cancellation Policy

Our goal is to provide quality individualized Chiropractic care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to Chiropractic care in a timely manner. We would like to remind you of our office policy regarding missed appointments and late cancellations. This policy enables us to better utilize available appointments for our patients in need of our care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Reyes Active Body Chiropractic at **814-308-9352**, or send us an email to **ReyesActiveBodyChiropractic@gmail.com** promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call one business day prior to your scheduled appointment.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: there will be no charge
- Second missed appointment and forward: **$30** fee will be charged to you

I have read and fully understand and agree to the terms of Reyes Active Body Chiropractic's No-Show/Cancellation policy.

PRINT: ______________________________

SIGN: ________________________________ DATE: __________