CONFIDENTIAL
PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient.
Please fill in all portions of the form. If you need any help, please ask the receptionist.

_____
DATE

How were you referred to our office? _____

Work No: _____
Home No: _____
Cell No: _____
Email: _____

PATIENT DATA

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ SS# _____

NAME OF NEAREST RELATIVE _____ PHONE # _____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ YOUR DRIVER'S LICENSE# _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

DATE OF FIRST SYMPTOMS _____ HAVE YOU HAD THIS CONDITION BEFORE? _____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION _____

❑ CANCER	❑ MUSCULAR DYSTROPHY	❑ RHEUMATIC FEVER
❑ POLIO	❑ MULTIPLE SCLEROSIS	❑ SCARLET FEVER
❑ TUBERCULOSIS	❑ CONVULSIONS	❑ NERVOUSNESS
❑ HIGH BLOOD PRESSURE	❑ EPILEPSY	❑ ASTHMA
❑ HEART TROUBLE	❑ CONCUSSION	❑ DIGESTIVE DISORDERS
❑ DIABETES	❑ DIZZINESS	❑ SINUS TROUBLE
❑ HEPATITIS	❑ ARTHRITIS	❑ BACKACHES
❑ GERMAN MEASLES	❑ NEURITIS	❑ NUMBNESS
❑ VENEREAL DISEASE	❑ RHEUMATISM	❑ ANEMIA

DESCRIBE THE OPERATIONS YOU'VE HAD: _____ WHEN _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ❑ YES ❑ NO _____

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ❑ YES ❑ NO WHAT KIND? _____

ARE YOU PREGNANT? ❑ YES ❑ NO DATE OF LAST MENSTRUAL PERIOD _____

All financial arrangements can be made at the second visit.
If insurance is involved, please bring in a completed and signed form at your next visit.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

I authorize examination and treatment of this child SIGNATURE _____

Signature of Parent of Minor Child

IS THIS VISIT DUE TO AN ACCIDENT OR WORK INJURY? ❑ YES ❑ NO *(If Yes, Notify receptionist)*

HIPPA Notice of Privacy Practices

Life Force Chiropractic
7704 Quarterfield Road, Suite H
Glen Burnie, MD 21061
(410) 760-4141

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding,, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe you privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

LIFE FORCE CHIROPRACTIC

You have made a wise selection coming to Life Force Chiropractic. Because of your decision, our office intends on providing you with optimal health through natural chiropractic care. In order for us to do so, we need to know which medications you are currently taking. For our records, please document the dosage and names of your prescribed and over-the-counter medications.

Please print your Primary Care Physician's name: _____

Please indicate your Primary Care Physician's phone #: _____-_____- _____

NAME OF MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN

X _____ _____

Patient Signature **Date**