SPINAL CARE ASSOCIATES

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we can begin any health care treatment we need you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI of the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient/ Parent or Guardian Date

305 NORTH BROADWAY EDMOND, OK. 73034 PHONE (405)348-5901 FAX (405)348-5923

## Office Policy

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If your account is not paid in 90 days from the date of service, and no financial arrangements have been made you will be responsible for any expenses incurred in collecting on your account.

## Authorization and Assignment of Benefits

I hereby authorize payment of benefits directly to provider of benefit due for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I also understand it is my responsibility to inform this office of any changes in my medical status or Insurance. The information that this office has is correct to the best of my knowledge.

Signature of Responsible Person: _____

Print Name: _____

Date: _____

# RELEASE OF INFORMATION

I give Dr. Burt Chappell, D.C./Spinal Care Associates permission to talk to the following people about my records/treatment (please print):

| Name | Relationship to Patient | Best Contact Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Signature: _____ Date: _____

Patient Name (please print): _____

# CONFIDENTAL PATIENT DATA

Today's Date:

## PATIENT INFORMATION

| Patient's last name: First: MI: | Nickname: | Date of Birth: | Sex: ❑M ❑F |
|---|---|---|---|
| Social Security Number: | Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other | | |
| Address: | City: | State: | Zip Code: |
| Home Phone: | Work Phone: | Cell Phone: | Preferred Phone: ❑Home ❑Work ❑Cell |
| E-mail address: | Employer: | | |
| Emergency Contact Name & Phone Number: | | | |
| Emergency Contact Address: | | | |

## HEALTH INSURANCE INFORMATION

| Primary Insurance: | Insured's ID: |
|---|---|
| Insured's Name: | Group Number: |
| Patient is the ❑Spouse ❑Child ❑Self ❑_____to the Insured. | Insured's Date of Birth: |
| Secondary Insurance: | Insured's ID: |

## OTHER PATIENT INFORMATION

| Referred by: | Referring Physician: |
|---|---|

Current Medications:

1. Drug Name: _____ 2. Drug Name: _____

Frequency (e.g. once daily) _____ Frequency (e.g. once daily)_____

3. Drug Name: _____ 4. Drug Name:_____

Frequency (e.g. once daily)_____ Frequency (e.g. once daily)_____

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year: Quit Date:

| Alcohol Use: ❑None ❑Light ❑Moderate ❑Heavy | Recreational Drug Use: ❑None ❑Light ❑Moderate ❑Heavy | Exercise: ❑None ❑Light ❑Moderate ❑Heavy |
|---|---|---|

## FAMILY HISTORY

Please indicate which conditions exist or have existed by marking the boxes below.

| | Self | Mother | Father | Sister | Brother | Son | Daughter |
|---|---|---|---|---|---|---|---|
| Arthritis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Blood Disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Dementia/Alzheimer's | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stomach/Intestinal Disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Kidney Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Lung Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Neurological Disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Psychological/Mental Disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other Patient Conditions | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Unknown Conditions | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Comment or Explain any conditions checked above:

Please list your complaints/symptoms in order from **WORST TO LEAST:**

1._____ 4._____

2._____ 5._____

3._____ 6._____

Please use **ONE PAGE <u>FOR EACH</u>** complaint or symptom

**SYMPTOM #____**

Complaint/symptom (choose one from previous page) :

Pain rating (1-10, with **10 being the worst imaginable**) :
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above Complaint/Symptom (choose ONE from your list on the previous page) :

**Pain Quality:**
❑None
❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

**Pain Frequency:**
❑None
❑Constant
❑Frequent
❑Intermediate
❑Occasional

**Pain radiates into:**
❑None
❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other:_____

**Pain Cause:**
❑None
❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

**Pain Pattern:**
❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

**What has been done before to treat this symptom?**
❑Acupuncture
❑Prescription Medicine
❑Massage
❑Surgery
❑Over the counter Medicine
❑None of the above

**Pain Duration:**
❑_____Day (s)
❑_____Week (s)
❑_____Month (s)
❑_____Year (s)

**Pain aggregated by:**
❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑None of the above
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

**Pain relieved by:**
❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head
❑None of the above

Other comments in regards to this complaint/symptom:

Please use **ONE PAGE <u>FOR EACH</u>** complaint or symptom

**SYMPTOM #____**

Complaint/symptom (choose one from previous page) :

Pain rating (1-10, with **10 being the worst imaginable**) :
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above Complaint/Symptom (choose ONE from your list on the previous page) :

**Pain Quality:**
❑None
❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

**Pain Frequency:**
❑None
❑Constant
❑Frequent
❑Intermediate
❑Occasional

**Pain radiates into:**
❑None
❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other:_____

**Pain Cause:**
❑None
❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

**Pain Pattern:**
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❑Worse in Evening
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❑Acupuncture
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❑Massage
❑Surgery
❑Over the counter Medicine
❑None of the above

**Pain Duration:**
❑_____Day (s)
❑_____Week (s)
❑_____Month (s)
❑_____Year (s)

**Pain aggregated by:**
❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑None of the above
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
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❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head
❑None of the above

Other comments in regards to this complaint/symptom:

Please use **ONE PAGE <u>FOR EACH</u>** complaint or symptom

**SYMPTOM #____**

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❑Left Leg
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❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other:_____

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❑Sitting
❑Standing
❑Typing
❑None of the above
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
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**Pain relieved by:**
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❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head
❑None of the above

Other comments in regards to this complaint/symptom:

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❑Sitting
❑Stretching
❑Turning Head
❑None of the above

Other comments in regards to this complaint/symptom: