

## NEW PRACTICE MEMBER INFORMATION

Today's Date: \_\_\_\_\_

HR#: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birthdate: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Marital Status:  Single  Married Do you have insurance?  Yes  No  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Number of children and ages: \_\_\_\_\_  
 Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

### HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: **Primary:** \_\_\_\_\_  
**Secondary:** \_\_\_\_\_ **Third:** \_\_\_\_\_ **Fourth:** \_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

<b>Primary</b> or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Second</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Third</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Fourth</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

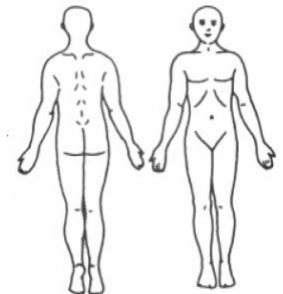
When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM  
 How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week  
 How did the injury happen? \_\_\_\_\_  
 Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when? \_\_\_\_\_ by whom? \_\_\_\_\_  
 How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_  
 Name of previous chiropractor: \_\_\_\_\_  N/A

**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_  
\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state what type of treatment: \_\_\_\_\_, and who provided it? \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable  
Please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with:

**P** for in the **Past**      **C** for **Currently** have      **N** for **Never** have had

\_\_\_ Broken Bone    \_\_\_ Dislocations    \_\_\_ Tumors    \_\_\_ Rheumatoid Arthritis    \_\_\_ Fracture    \_\_\_ Disability    \_\_\_ Cancer  
\_\_\_ Heart Attack    \_\_\_ Osteo Arthritis    \_\_\_ Diabetes    \_\_\_ Cerebral Vascular    \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE IDENTIFY ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
<b>INJURIES</b>			
<b>SURGERIES</b>			
<b>CHILDHOOD DISEASES</b>			
<b>ADULT DISEASES</b>			

**FAMILY HISTORY**

1. Does anyone in your family suffer with the same condition(s)?  No  Yes **If yes**, whom?  
 grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know

2. Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes    How often?  Daily       Weekends       Occasionally       Never
- 2. **Alcoholic Beverage:** consumption occurs       Daily       Weekends       Occasionally       Never
- 3. **Recreational Drug use:**       Daily       Weekends       Occasionally       Never
- 4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to [INSERT PRACTICE NAME], for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [INSERT PRACTICE NAME] for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

### ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES:**

**EFFECT:**

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please mark: **P** for in the **Past**

**C** for **Currently** have

**N** for **Never**

<input type="checkbox"/> Headache	<input type="checkbox"/> Pregnant (Now)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Impotence/Sexual Dysfun.	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Jaw Pain, TMJ	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Heart Problem
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Tremors	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pain w/Cough/Sneeze	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Menopausal Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Foot or Knee Problems	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Menstrual Problem	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sinus/Drainage Problem	<input type="checkbox"/> Depression	<input type="checkbox"/> PMS	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Numb/Tingling arms, hands, fingers		<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Numb/Tingling legs, feet, toes		<input type="checkbox"/> Allergies	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Hepatitis (A,B,C)

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

Subluxation / Palpation			
Level	L/R	Pain	Spasm
Occ			
C1			
C2			
C3			
C4			
C5			
C6			
C7			
T1			
T2			
T3			
T4			
T5			
T6			
T7			
T8			
T9			
T10			
T11			
T12			
L1			
L2			
L3			
L4			
L5			
R. SI			
L. SI			
Sacrum			
Coccyx			

Orthopedic Tests C/S						
	Test	Findings				Notes
<input type="checkbox"/>	George's	+	-	R	L	
<input type="checkbox"/>	Distraction	+	-	R	L	
<input type="checkbox"/>	Max. Comp.	+	-	R	L	Ipsi/Contra
<input type="checkbox"/>	O'Donahue's	+	-	R	L	
<input type="checkbox"/>	Soto Hall	+	-	R	L	
<input type="checkbox"/>	Shoulder Dep.	+	-	R	L	
<input type="checkbox"/>	Valsalva's	+	-	R	L	
<input type="checkbox"/>	Spinal Perc.	+	-	R	L	Level
<input type="checkbox"/>	Finger/Nose	WNL		BNL		
<input type="checkbox"/>	Adson's	+	-	R	L	
<input type="checkbox"/>	Schepelmann	+	-	R	L	
<input type="checkbox"/>	Mazion's	+	-	R	L	
<input type="checkbox"/>	Impingement	+	-	R	L	
<input type="checkbox"/>	Gait	WNL		Abn.		

Orthopedic Tests L/S						
<input type="checkbox"/>	SLR	+	-	R	L	at _____ °
<input type="checkbox"/>	Braggard's	+	-	R	L	
<input type="checkbox"/>	Faber Patrick	+	-	R	L	
<input type="checkbox"/>	Kemp's	+	-	R	L	
<input type="checkbox"/>	Valsalva's	+	-	R	L	
<input type="checkbox"/>	Yeoman's	+	-	R	L	
<input type="checkbox"/>	Ely's	+	-	R	L	
<input type="checkbox"/>	Toe Walk	+	-	R	L	
<input type="checkbox"/>	Heel Walk	+	-	R	L	
<input type="checkbox"/>	Sacral Apex	+	-	R	L	
<input type="checkbox"/>	Erichsen's	+	-	R	L	
<input type="checkbox"/>	Abduction Str	+	-	R	L	
<input type="checkbox"/>	Adduction Str	+	-	R	L	
<input type="checkbox"/>	Lachman's	+	-	R	L	
<input type="checkbox"/>	Drawer Sign	+	-	R	L	

Posture		
Area	Findings	
F H P	+	-
Head Tilt	R	L
Head Rot.	R	L
↑ Shoulder	R	L
Thor. Tilt	R	L
Thor. Trans	R	L
↑ Hip	R	L
Hip Rot.	R	L
Foot Flare	R	L
Short Leg	R	L
Bilat.	Weight	
-Left	-Right	

Pulse \_\_\_\_\_  
 BP \_\_\_\_\_ / \_\_\_\_\_  
 Temp \_\_\_\_\_  
 Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 Notes: \_\_\_\_\_

Medicare – Insurance/Cash – PIP/WC	
Tension HA (uncontrolled)	Radiculopathy
Tension HA (controlled)	(C) (C/T) (T) (T/L) (L)
Migraine (uncontrolled)	
Migraine (controlled)	L Fusion
Neck Pain (Mid) (Low)	L/S Fusion
C Disc Degeneration (High)	L Spinal Instability
C Disc Degeneration (C4-C5) (C5/C6) (C6/C7)	L/S Spinal Instability
C/T Disc Degeneration	L Disc Disorder
C Disc Displacement (High)	L/S Disc Disorder
C Disc Displacement (Mid) (C4-C5) (C5/C6) (C6/C7)	Sciatica Right
C/T Disc Displacement (C7-T1)	Sciatica Left

Sub/Obj  
C/I  
Not C/I

Scan  
Intake   
Exam

PART  
Ins. Auto

X-Ray  
C-T-L/P-P/A  
  
Posture  
Trauma

Ass I/C  
Full  
Partial  
Some

OATS  
Base \_\_\_\_\_  
Goal \_\_\_\_\_

Tx Plan 98940 – 41 – 42 \_\_\_ X \_\_\_ weeks

98943 \_\_\_\_\_ 97124 \_\_\_\_\_  
 97012 \_\_\_\_\_ 97140 \_\_\_\_\_  
 97032 \_\_\_\_\_ 97150 \_\_\_\_\_  
 97110 \_\_\_\_\_ \_\_\_\_\_

Examiner/Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

Muscle Strength		
Muscle	R Strength	L Strength
Biceps	0 1 2 3 4 5	0 1 2 3 4 5
Brachio	0 1 2 3 4 5	0 1 2 3 4 5
Wrist Ext	0 1 2 3 4 5	0 1 2 3 4 5
Triceps	0 1 2 3 4 5	0 1 2 3 4 5
Finger Ext	0 1 2 3 4 5	0 1 2 3 4 5
Finger Ab / Ad	0 1 2 3 4 5	0 1 2 3 4 5
Grip	0 1 2 3 4 5	0 1 2 3 4 5
Hip Flexion	0 1 2 3 4 5	0 1 2 3 4 5
Hip AB	0 1 2 3 4 5	0 1 2 3 4 5
Hip AD	0 1 2 3 4 5	0 1 2 3 4 5
Hip Ext	0 1 2 3 4 5	0 1 2 3 4 5
Knee Flex	0 1 2 3 4 5	0 1 2 3 4 5
Knee Ext.	0 1 2 3 4 5	0 1 2 3 4 5
Ankle D. Flex	0 1 2 3 4 5	0 1 2 3 4 5
Ankle P Flex	0 1 2 3 4 5	0 1 2 3 4 5

All Tests = WNL (5)

Reflexes	
Reflex	Grade
L Bicep	0 1 2 3 4
L Tricep	0 1 2 3 4
L Brachio	0 1 2 3 4
R Bicep	0 1 2 3 4
R Tricep	0 1 2 3 4
R Brachio	0 1 2 3 4
L Patellar	0 1 2 3 4
L Achilles	0 1 2 3 4
R Patellar	0 1 2 3 4
R Achilles	0 1 2 3 4

All Tests WNL (2)

Dermatomes				
Level	↑	N	↓	Notes
C5				
C6				
C7				
C8				
T1				
L3				
L4				
L5				
SI				

L=Left R=Right

All Tests WNL

ROM – Normal in ( ) P – Pain S – Stiffness R - Radiating			
<b>L-Shoulder ROM</b>	Flexion (180) _____ (P S R)	Internal Rotation (75) _____ (P S R)	Abduction (150) _____ (P S R)
	Extension (60) _____ (P S R)	External Rotation (90) _____ (P S R)	

<b>R-Shoulder ROM</b>	Flexion (180) _____ (P S R)	Internal Rotation (75) _____ (P S R)	Abduction (150) _____ (P S R)
	Extension (60) _____ (P S R)	External Rotation (90) _____ (P S R)	

<b>L-Hip ROM</b>	Flexion (125) _____ (P S R)	Internal Rotation (40) _____ (P S R)	Abduction (145) _____ (P S R)
	Extension (30) _____ (P S R)	External Rotation (60) _____ (P S R)	Adduction (25) _____ (P S R)

<b>R-Hip ROM</b>	Flexion (125) _____ (P S R)	Internal Rotation (40) _____ (P S R)	Abduction (145) _____ (P S R)
	Extension (30) _____ (P S R)	External Rotation (60) _____ (P S R)	Adduction (25) _____ (P S R)

<b>L-Knee ROM</b>	Flexion (140) _____ (P S R)	Extension (10) _____ (P S R)
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<b>R-Knee ROM</b>	Flexion (140) _____ (P S R)	Extension (10) _____ (P S R)
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Examiner/Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Functional Neurology Tests:**

	Normal	Left	Right
Pupils (C)			
Pursuits (C)			
Convergence ©			
Head Tilt ©			
Rhomberg ©			
Single Leg ©			
Pinky to Nose ©			

(C) = Cortex. © = Cerebellum

**Weakness**

Rt Cortex	Lt Cortex
Rt Cerebellum	Lt Cerebellum

Examiner/Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Turning Point Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_/\_\_\_/\_\_\_  
Date



Witness Initials

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY:** Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.

The first day of my last menstrual cycle was on \_\_\_-\_\_\_-\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_/\_\_\_/\_\_\_  
Date



Witness Initials



## Turning Point Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Arnold Koo at (925) 396-8004 If she/he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Patient initials:** \_\_\_\_\_ -retaining page 1 of 2

***Turning Point Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...***

I have received a copy of Turning Point Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
HR#

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

*Medical Information Release Form  
(HIPAA Release Form)*

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Release of Information:**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages:**

Please call  my home  my work  my mobile number: \_\_\_\_\_

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

\_\_\_\_\_

The best time to reach me is (*day*) \_\_\_\_\_ between (*time*) \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_