Patient Health History

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____
First MI Last

Nick Name _____ **Suffix** _____

Address 1 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Email _____

By providing my email address, I authorize the office to contact me via the email for Clinic Updates, Announcements & Birthday Cards.

Patient Identification: **Please Complete Entire Section**

Date of Birth: / /

Age _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Patient SSN _____

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other Spouse Name:_____

Employment Status: *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer Name: _____ Phone: _____

Insured Data Policy Holder: *(check one)*

❑ Self ❑ Spouse ❑ Parent ❑ Other ❑ Employee

Insured Name: _____ **Date of Birth** / /

Emergency Contact

Name: _____ Phone: _____

Relation *(check one)* ❑ Spouse ❑ Sibling ❑ Parent ❑ Son/Daughter ❑ Friend ❑ Employee

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Chinese ❑ I choose not to specify ❑ Other _____

Multi-Racial ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑English ❑Spanish ❑American Sign Language ❑I chose not to specify

How did you hear about our office? Whom may we thank for your referral? *(check one)*

❑ Family Member* ❑ Living Social ❑ Internet Web Site ❑ Google
❑ Attorney* ❑ ValPak ❑ Sign on Building ❑ Yahoo
❑ Friend* ❑ Groupon ❑ Dex Phone Book ❑ Bing
❑ Physician* ❑ Direct mail ❑ Yellow Book ❑ Other

*Please Describe _____

Security Verification Question: (Please Select ONE by checking the box and answering that question)

❑What City were you born? ❑What's your mother's Maiden name? ❑ What street did you grow up on?

Verification Answer: (answer must be 6 characters long)_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ No Past Tobacco Use ❑ Yes ❑ No

If yes, how long have you smoked or chewed? _____ **Amount per day** _____

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

Have you ever seen a Chiropractor, M.D. or D.O. for Spinal Manipulation before? ❑ Yes ❑ No

Have you ever had Acupuncture before? ❑ Yes ❑ No

Have you ever had Physical Therapy or Rehabilitation before? ❑ Yes ❑ No

Current medications and dosage(*this includes any non-prescription or homeopathic vitamins or supplements)*

If there are no current medications, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List any known allergies you have had to any medications and interaction.

If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

<u>To Be Performed by Clinic Staff</u>**:** Date_____

Staff _____

Height _____ Weight _____ Blood Pressure _____/_____

Pulse _____

Reason for visit today (primary complaint):

_____

_____

_____

When did your symptoms start? / /

How did your symptoms begin? ❑ Auto Injury ❑ Work Injury ❑ Slip or Fall ❑ Sports Injury ❑ Lifting

❑ Prolonged Driving ❑ Excessive Standing/Walking ❑ Repetitive Motion ❑ Reaching ❑ Vacuuming

❑ Sitting at Computer ❑ Household Chores ❑ Lawn work ❑ Shoveling ❑ Violent Sneeze or Cough

❑ Other _____

How often do you experience your symptoms throughout the day?

❑ 0 - 25% ❑ 26 - 50% ❑ 51 - 75% ❑ 76 - 100%

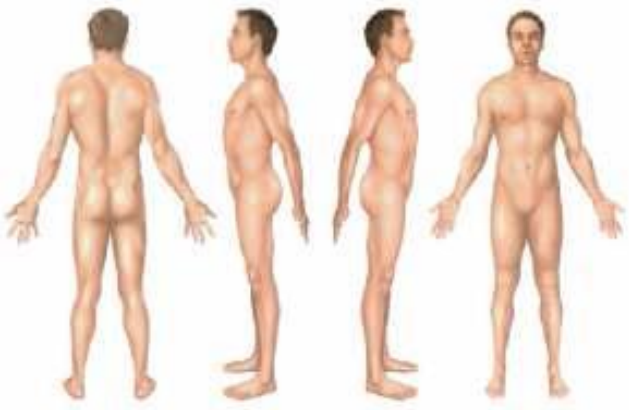
Rate your intensity of pain for the region of complaint: (0= No Pain 5 = Moderate 10 = Unbearable)

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Additional Complaints: 2. _____3. _____

4. _____5. _____

By using the diagram below, please indicate on the body where you are experiencing your symptoms:



What describes the nature of your symptoms?

❑ Dull ❑Sharp ❑ Throbbing ❑ Burning ❑Tingling

❑ Stabbing ❑ Cramping ❑ Numbness ❑ Radiating

❑ Other_____

How are your symptoms changing throughout the day?

❑ Getting Better ❑Same ❑Getting Worse

Does your pain wake you up at night? ❑ Yes ❑ No

Does your pain travel or radiate from one part of your body to the other? ❑ Yes ❑ No (if Yes please indicate on diagram)

Have you applied Ice to the affected area? ❑ Yes ❑ No *If Yes did the condition get: ❑ Better ❑ Worse ❑ Same

Have you applied Heat to the affected area? ❑Yes ❑ No *If Yes did the condition get: ❑ Better ❑ Worse ❑ Same

Have you seen anyone else for this condition? ❑ Yes ❑ No *If Yes Whom: _____

Is there anything that makes your condition better? _____

Is there anything that makes your condition worse? _____

Additional information may be provided in the space below:

Dr. John Pleggenkuhle
Pleggenkuhle Chiropractic
317 Hwy 150 North
West Union, Iowa 52175

Phone: 563.422.9999
Fax: 563.422,9990
www.northfayettechiro.com

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click."

INFORMED CONSENT TO THIRD PARTY PAYER

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Financial Policy

Insurance Coverage

Welcome to **Pleggenkuhle Chiropractic.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

Payment Options

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Choose One Option A-F

CASH:

A_____ I want to pay with CASH or CREDIT for each treatment. As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance:

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment including deductible, co-pays or co-insurance.

Personal Injury:

D_____I want to use my Med Pay – Insurance through my own auto insurance coverage. Med pay will pay your bill as you go, and be reimbursed from the at-fault insurance when you settle. If your med pay insurance is exhausted before your treatment is complete, then the at-fault insurance company will be billed.

E____ I want to use my personal insurance. (If you are a Blue Cross Blue Shield participant you must choose this option as they require all claims be sent directly to them).

F____ I want to pay with CASH or CREDIT for each treatment. I understand that I can turn the receipt of payment into my Med-Pay or At-Fault for reimbursement when I settle.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date

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 CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:
Without your signed authorization:
• Treatment
• Payment
• Health care operations
• When release is required by law, including in judicial settings and to health oversight regulatory agencies and law enforcement.
• In emergency situations or to avert serious health/safety situations.
• To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
• To organ, tissue and other donation organizations, upon or proximate to your death if you have no indication on hand about your donation preferences.
Special cases
• To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
• To the sponsor of your health plan.
Other
• All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.
Your rights: You have the following rights concerning your PHI:
Restrictions: To request restricted access to all or part of your PHI. We are not required to grant your request.
Confidential communications: To received correspondences of confidential information by alternate means or location.
Access: To inspect or receive copies of your protected health information.
Amendments: To request changes be made to your PHI. We are not required to grant your request.
Accounting: To receive an accounting of the disclosure by us of your PHI in the six years prior to your request.
This notice: To get updates or reissue of this notice, at your request.
Complaints: To complain to us or the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated. The law forbids us from taking retaliatory action against you if you complain.
Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Pleggenkuhle Chiropractic is in compliance with the HIPAA Omnibus Rule. Pleggenkuhle Chiropractic will not disclose Private Health Information without authorized permission from a patient. Private Health Information would be used/disclosed with authorized permission for marketing purposes. If you do not give express permission, we will not use your information for marketing purposes. If a patient requests a digital copy of certain electronic Private Health Information or directs Dr. Pleggenkuhle in writing to transmit a copy to another person, Dr. Pleggenkuhle will produce the information in the format requested (if readily producible) within 30 days or negotiate an alternative format. Further, if a patient requests that a copy of his or her Private Health Information be sent via unencrypted email, the Dr. Pleggenkuhle will be permitted to do so, providing that the patient is aware of the risks and prefers the unencrypted email. Please be aware that Dr. Pleggenkuhle has the means to send *some* Private Health Information via encrypted email. If a patient would prefer an encrypted email, please inform Dr. Pleggenkuhle or a Pleggenkuhle Chiropractic Staff Member.

As a patient, you have a right to restrict any disclosures made to health plans for payment or health care operations purposes if the Private Health Information pertains to an item or service for which you paid COMPLETELY out of pocket.

Pleggenkuhle Chiropractic has completed a Risk Assessment regarding Private Health Information and has found no breaches in security. If in the event a breach occurs Pleggenkuhle Chiropractic will inform affected patients and perform another Risk Assessment to address any changes that need to be made. Pleggenkuhle Chiropractic takes the protection of Private Health Information very seriously and maintains strict compliance with any and all HIPAA requirements.

To read the HIPAA Omnibus Rule in its entirety and how it may pertain to you please visit:
http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

By signing you are acknowledging that you have read the Update Privacy Policy.

_____ _____

Signature: Patient or Legal Representative Date Signed

Relationship to Patient: _____