

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_

PREFERRED TO BE CALLED \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ REFERRED BY \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

IF YOU ARE NOT RETIRED, A HOMEMAKER, OR A STUDENT, WHAT IS YOUR CURRENT WORK STATUS?  FULL-TIME  SELF-EMPLOYED  OFF WORK  PART-TIME  UNEMPLOYED  OTHER

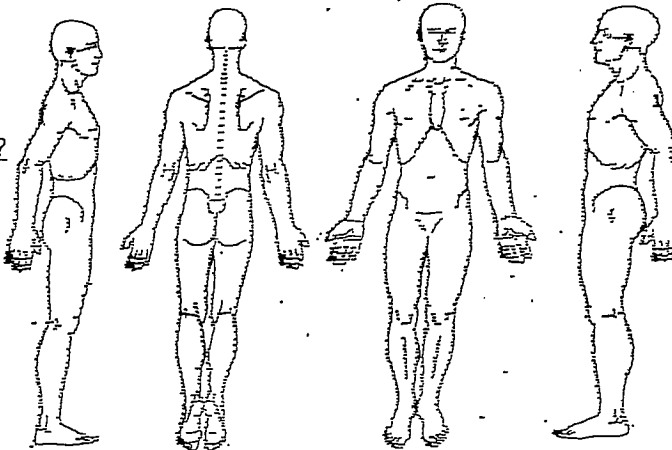
IS THIS A GENERAL CHECK-UP/WELL VISIT? YES NO  
IS THIS YOUR FIRST CHIROPRACTIC VISIT? YES NO  
WOMEN: ARE YOU PREGNANT? YES NO  
LAST PHYSICAL EXAM \_\_\_\_\_  
DUE DATE \_\_\_\_\_

1. WHAT IS YOUR MAJOR COMPLAINT? \_\_\_\_\_  
2. WHEN DID YOUR SYMPTOMS START? \_\_\_\_\_ 3. DESCRIBE YOUR SYMPTOMS AND HOW THEY BEGAN: \_\_\_\_\_

4. HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- CONSTANTLY (76-100% OF THE DAY)
- FREQUENTLY (51-75% OF THE DAY)
- OCCASIONALLY (26-50% OF THE DAY)
- INTERMITTENTLY (0-25% OF THE DAY)

5. INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS ↓



6. WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- SHARP  SHOOTING
- DULL ACHE  BURNING
- NUMB  TINGLING

7. HOW ARE YOUR SYMPTOMS CHANGING?

- GETTING BETTER
- NOT CHANGING
- GETTING WORSE

8. HOW BAD ARE YOUR SYMPTOMS AT THEIR:

	NONE										UNBEARABLE
A. WORST:	0	1	2	3	4	5	6	7	8	9	10
B. BEST:	0	1	2	3	4	5	6	7	8	9	10

9. HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO

A. IF SO, WHO DID YOU SEE?  THIS OFFICE  MEDICAL DOCTOR  OTHER  
 OTHER CHIROPRACTOR  PHYSICAL THERAPIST

10. WHAT ACTIVITIES MAKE YOUR SYMPTOMS WORSE? \_\_\_\_\_

11. WHAT ACTIVITIES MAKE YOUR SYMPTOMS BETTER? \_\_\_\_\_

12. WHO HAVE YOU SEEN FOR YOUR SYMPTOMS?

- NO ONE  MEDICAL DOCTOR  OTHER
- OTHER CHIROPRACTOR  PHYSICAL THERAPIST

A. WHEN AND WHAT TREATMENT? \_\_\_\_\_

B. WHAT TESTS HAVE YOU HAD FOR YOUR SYMPTOMS AND WHEN WERE THEY PERFORMED?

XRAYS DATE \_\_\_\_\_  CT SCAN DATE \_\_\_\_\_  
 MRI DATE \_\_\_\_\_  OTHER \_\_\_\_\_ DATE \_\_\_\_\_

13. WHAT DO YOU HOPE TO GET FROM YOUR VISIT/TREATMENT? (SELECT ALL THAT APPLY)

- REDUCE SYMPTOMS  EXPLANATION OF CONDITION/TREATMENT  RESUME/INCREASE ACTIVITY
- HOW TO PREVENT THIS FROM OCCURRING AGAIN  LEARN HOW TO TAKE CARE OF THIS ON MY OWN

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

----- OFFICE USE ONLY -----

INS: CASH WC PI PRIVATE INS 1<sup>ST</sup> \_\_\_\_\_ 2<sup>ND</sup> \_\_\_\_\_

# Adirondack Family Chiropractic, P.C.

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent and confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the advice of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read  
(print name)

and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

ADIRONDACK FAMILY CHIROPRACTIC, P.C.

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.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. governmental regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Julie Shiflett, Office Manager is in charge of privacy matters at our office. You can contact her at (518)-561-6004 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. We will disclose PHI to other physicians who may be treating you, your PHI may be provided to a physician to whom you have been referred to insure that the physician has the necessary information to diagnosis or treat you.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Most health plans require us to supply diagnosis and treatment codes and description of services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. We may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. required by a health oversight agency for oversight activities authorized by law, such as Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. Space for this provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the request amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payments or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR-164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

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

We are required to abide by the terms of this notice as long as it s currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Julie Shiflett, Office Manager, 1942 Military Turnpike, Plattsburgh, New York 12901, (518) 561-6004.

No retaliatory action can be taken against you for any complaint you make.

- I have received a paper copy of this notice.
- I do not wish to receive a paper coy of this notice at this time.

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

Print Name: \_\_\_\_\_

I make the following special request for confidential communications:  
\_\_\_\_\_  
\_\_\_\_\_

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