2373 E. Baseline Road, Suite 102
Gilbert, AZ 85234
(480) 393-0440 phone
(602) 842-7057 fax
www.gilbertchirowellness.com

PATIENT INFORMATION

Name ______________________________ Date ______________ S/S ______________
First MI Last

Address ______________________ City ______________ State ________ Zip ________

Gender ☐ Female ☐ Male

Birth Date ______________ Home phone ______________ Work phone ______________

Are you ☐ Minor ☐ Married ☐ Single

Your employer ______________________ Occupation ______________________

Business Address ______________________ City ______________ State ________ Zip ________

Spouse or Parent's Name ______________ Workplace ______________ Work Phone ______________

Person to contact in case of emergency ______________________ Phone ______________

Whom may we thank for referring you to us? ______________________

How will you be paying for your care? ☐ Cash ☐ Credit ☐ Personal Insurance ☐ Worker's Comp.
☐ Auto Insurance ☐ Medicare ☐ Medicaid

INSURANCE INFORMATION

PRIMARY – *please present insurance card and drivers license to receptionist.*

Name of Insured ______________________ Relationship to Patient ______________

Birth Date ______________ Social Security # ______________ Phone # ______________

Name of employer ______________________ Work phone ______________

Address ______________________ City ______________ State ________ Zip ________

Insurance Co. ______________ Group # ______________ Employee ID# ______________

Phone ______________ Address ______________ City ______________ State ________ Zip ________

SECONDARY – *please present insurance card to receptionist.*

Name of Insured ______________________ Relationship to Patient ______________

Birth Date ______________ Social Security # ______________ Phone # ______________

Name of employer ______________________ Work phone ______________

Address ______________________ City ______________ State ________ Zip ________

Insurance Co. ______________ Group # ______________ Employee ID# ______________

Phone ______________ Address ______________ City ______________ State ________ Zip ________

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records on any care or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In addition, I authorize Gilbert Chiropractic & Wellness to release a medical report to my primary medical provider, if necessary.

X____

Signature of Patient (or parent if a minor) *Date*

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PATIENT NAME ____________________

What is reason you are seeing the doctor today? ____________________

Is the purpose of this visit: ☐ Job related ☐ Auto Accident ☐ Home Injury ☐ Other

a) If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

b) Date and Time of Accident? ____________________

Other doctor(s) seen for this condition and results? ____________________

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No

Describe ____________________

What medications are you currently taking? ____________________

Remarks or additional information ____________________

Have you received Chiropractic care before? ☐ Yes ☐ No

DOCTOR'S NAME	REASON	DATE OF LAST VISIT

Do you wear a shoe lift? ☐ Yes ☐ No

HEALTH HISTORY

List ***ALL*** Surgeries/Operations: ____________________

Hospitalization (other than above): ____________________

Have you EVER been diagnosed with or told you have the following?

- Y N High blood pressure
- Y N Hardening of the arteries
- Y N Diabetes
- Y N Heart or blood vessel disease
- Y N Bone spurs on the neck
- Y N Whiplash Injury
- Y N Any relatives ever suffer a stroke?
- Y N Blurred vision
- Y N Double vision
- Y N Do you currently smoke?
- Y N Have you smoked in the past?

Have you had any of the following symptoms within the last year?

- Y N Slurred speech or other speech problems
- Y N Difficulty swallowing
- Y N Dizziness
- Y N Temporary lack of understanding
- Y N Loss of consciousness / momentary blackouts
- Y N Numbness or loss of sensation in any extremity
- Y N Any abnormal or loss of sensation in the body
- Y N Weakness, clumsiness, or strength loss
- Y N Sudden collapse without loss of consciousness
- Y N Diminished or partial loss of vision
- Y N Hearing loss in one or both ears

*X*____________________

Signature of Patient (or parent if a minor) *Date*

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INFORMED CONSENT TO CHIROPRACTIC CARE

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered by the patient may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

____
Printed Name

____ ________________________
Signature Date

WITNESS:

____
Printed Name

____ ________________________
Signature Date

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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 IT CAREFULLY.

Your medical information is the information gathered by your chiropractor or other caregivers during the time Richard L. Rodgers, II, D.C. ("Gilbert Chiropractic & Wellness") professionals are treating you. It is private and no one without a legitimate need to know may have access to it. Gilbert Chiropractic & Wellness is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices.

Gilbert Chiropractic & Wellness will not use or disclose your health information except as described in this notice. This notice applies to all of the medical records generated during your participation in Gilbert Chiropractic & Wellness programs and services.

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

The following categories describe the ways that Gilbert Chiropractic & Wellness may use and disclose your health information:

Appointment Reminders:
Gilbert Chiropractic & Wellness may use and disclose medical information to contact you as a reminder that you have an appointment for treatment at Gilbert Chiropractic & Wellness.

Treatment:
Gilbert Chiropractic & Wellness may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Payment:
Gilbert Chiropractic & Wellness may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payer might include information that identifies you, your diagnosis, or the procedures and supplies used.

Routine Healthcare Operations:
Gilbert Chiropractic & Wellness may use and disclose your medical information during routine healthcare operations, including quality assurance, utilization review, internal auditing, accreditation, certification, licensing or credentialing activities of the Clinic, medical research and educational purposes.

Business Associates:
Gilbert Chiropractic & Wellness may use and disclose certain medical information about you to business associates. A business associate is an individual or entity under contract with Gilbert Chiropractic & Wellness to perform or assist Gilbert Chiropractic & Wellness in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the Clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third-party billing companies. Gilbert Chiropractic & Wellness requires the business associate to protect the confidentiality of your medical information.

Regulatory Agencies:
Gilbert Chiropractic & Wellness may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, the State Auditor may audit billing practices and records are subject to review by the Secretary of Health and Human Services and his authorized representatives.

Worker's Compensation:
Gilbert Chiropractic & Wellness may release medical information about you for worker's compensation or similar programs that provide benefits for work-related injuries or illnesses.

Military Veterans:
Gilbert Chiropractic & Wellness may disclose your medical information as required by military command authorities if you are a member of the armed forces.

Inmates:
If you are an inmate of a correctional institution or under the custody of a law enforcement officer, Gilbert Chiropractic & Wellness may release your medical record information to the correctional institution or law enforcement official.

Required by Law:
Gilbert Chiropractic & Wellness will disclose medical information about you when required to do so by law.

Other Uses:
Any other uses and disclosures will be made only with your written authorization.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained by Gilbert Chiropractic & Wellness are the property of Gilbert Chiropractic & Wellness, you have the following rights concerning your medical information:

Right to Confidential Communications:
You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that the Gilbert Chiropractic & Wellness contact you only at work or by mail.

Right to Inspect and Copy:
You have the right to inspect and copy your medical information.

Right to an Accounting:
You have the right to obtain an accounting of the disclosures of your medical information.

Right to Request Restrictions:
You have the right to request restrictions on certain uses and disclosures of your medical information. Gilbert Chiropractic & Wellness is not requested to honor your request.

Right to Revoke Authorization:
You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, IN WRITING, to Richard L. Rodgers, II, D.C., Inc. d/b/a Gilbert Chiropractic & Wellness. Forms to help you make your request are available in the Clinic.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our HIPPA Privacy Officer, at (480) 393-0440. If you believe your privacy rights have been violated, you may file a complaint with Gilbert Chiropractic & Wellness or with the Secretary of the Department of Health and Human Services. To file a complaint with Gilbert Chiropractic & Wellness, please contact the reception area located near the front entrance of the Clinic. All complaints must be submitted in writing.

CHANGES TO THIS NOTICE

Gilbert Chiropractic & Wellness will abide by the terms of the notice currently in effect. Gilbert Chiropractic & Wellness reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. An updated version of the NOTICE may be obtained at the Clinic.

NOTICE EFFECTIVE DATE

The effective date of this Notice is April 14, 2003.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES
GILBERT CHIROPRACTIC & WELLNESS

I certify that I have received a copy of the Gilbert Chiropractic & Wellness Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gilbert Chiropractic & Wellness' health care operations. The Notice of Privacy Practices also describes my rights and Gilbert Chiropractic & Wellness' duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the reception area.

Richard L. Rodgers, II, D.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date