Dr. Lena K. Fugate, D.C., CICE

Dr. Josh B. Bakun, D.C.
M.S. Sport Health Science

Fugate Family Chiropractic

PHONE: 606-439-3399 * FAX: 606-487-9280 * 100 VETERANS DR. * HAZARD, KY 41701

PATIENT INFORMATION **TODAY'S DATE:** _____

NAME: _____ _____DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
PERFERRED # CELL___HOME___WORK___ EMAIL ADDRESS: _____
SOCIAL SECURITY # _____-_____-_____ AGE: _____ MALE_____ FEMALE _____
MARITAL STATUS: MARRIED ____ SINGLE ____ DIVORCED ____ SEPERATED ____ OTHER ____
NAME OF SPOUSE OR NEAREST RELATIVE: _____ PHONE #: _____
YOUR OCCUPATION: _____ YOUR EMPLOYER: _____
REFERRED TO THIS OFFICE BY: ___FRIEND/FAMILY MEMBER – NAME? _____
___ YELLOW PAGES ___ MAIL ___ CLINIC LOCATION ___ OTHER_____
NAME OF INSURANCE COMPANY: _____ INSURED'S EMPLOYER: _____
INSURED'S SOCIAL SECURITY # _____ INSURED'S DATE OF BIRTH: _____
EMPLOYER'S PHONE #_____
ARE YOU COVERED BY MORE THAN ONE INSURANCE COMPANY? ___YES ___NO NAME: _____

DO YOU HAVE A PACEMAKER? ___YES ___NO
HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITIONS IN THE LAST YEAR? ___YES ___NO

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY TO YOU)

___ARTHRISTIS	___CANCER	___DIABETES	___HEART DISEASE
___HYPERTENSION	___SKIN DISORDER	___STROKE	___OTHER _____

SURGERIES (CHECK ALL THAT APPLY TO YOU)

___APPENDECTOMY	___PROSTATE	___CERVICAL SPINE	___KNEE
___JOINT REPLACEMENT	___SHOULDER	___THORACIC SPINE	___HERNIA
___BRAIN	___GASTRO-INTESTINAL	___LUMBAR SPINE	___URO-GENITAL
___CARPAL TUNNEL	___GALLBLADDER	___HYSTERECTOMY	___OTHER _____

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU)

CAFFEINE USE:	___occasional	___often	___never
DRINK ALCHOL:	___occasional	___often	___never
EXERCISE:	___occasional	___often	___never
CIGARETTES:	___<1 pack/day	___>1 pack/day	___never

FAMILY HISTORY (M=MOTHER, F=FATHER, S=SISTER, B=BROTHER)

ARTHRITIS:	___parent	___sibling	HYPERTENSION:	___parent	___sibling
CANCER:	___parent	___sibling	STROKE:	___parent	___sibling
DIABETES:	___parent	___sibling	THYROID:	___parent	___sibling
HEART DISEASE:	___parent	___sibling	OTHER: _____		

ACCIDENT HISTORY

___JOB ___AUTO ___OTHER 1._____ DATE: _____
___JOB ___AUTO ___OTHER 2._____ DATE: _____

Initial_____

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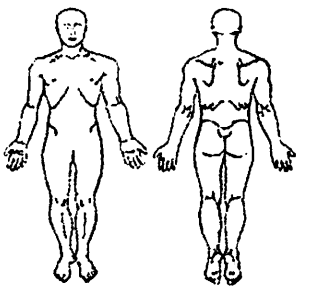
PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

_____

_____

SYMPTOMS ARE WORSE IN: ___MORNING
___AFTERNOON
___NIGHT

MARK AREAS OF PAIN:



WHEN DID YOUR SYMPTOMS APPEAR?

_____

_____

SYMPTOMS DEVELOPED FROM:

___JOB ___ILLNESS ___OTHER
___AUTO ACCIDENT ___UNKNOWN CAUSE ___GRADUAL ONSET
DATE OCCURRED_____

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ___DAY(S) ___WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ___COME AND GO ___ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ___YES ___NO WHEN? _____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

ARE YOU PREGNANT? ___YES ___NO IF SO, HOW FAR ALONG? _____
DATE OF YOUR LAST MENSTRUAL CYCLE? _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

___BENDING ___COUGHING ___LIFTING ___LYING DOWN
___REACHING ___SITTING ___SNEEZING ___STANDING
___STRAINING AT STOOL ___TURNING HEAD ___WALKING ___OTHER:_____

PLEASE CHECK THE FOLLOWING THAT RELIEVE YOUR CONDITION:

___BENDING ___STANDING ___REACHING
___SITTING ___LYING DOWN ___WALKING
___LIFTING ___TURNING HEAD ___OTHER:_____

PLEASE CHECK ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

___BLURRED VISION ___BUZZING IN EARS ___CONSTIPATION
___COLD SWEATS ___CONFUSION ___DIZZINESS
___DEPRESSION ___DIARRHEA ___FEVER
___FAINTING ___FATIGUE ___LOSS OF BALANCE
___HEADACHES ___SENSITIVE TO LIGHT ___MUSCLE JERKING
___INSOMNIA ___PINS/NEEDLES IN ARMS ___PINS/NEEDLES IN LEGS
___NUMBNESS IN TOES ___STIFF NECK ___STOMACH UPSET
___SHORTNESS OF BREATH ___COLD FEET ___COLD HANDS
___LOSS OF SMELL ___NUMBNESS IN FINGERS ___RINGING IN EARS
___HEAD SEEMS HEAVY ___LOW RESISTANCE TO COLD ___OTHER:_____

PATIENT'S SIGNATURE_____ **DATE**_____

INITIAL_____

Review of Systems:
Please check all that apply

PATIENTS NAME:_____
DATE:_____

Cardiovascular				Respiratory				Allergic			
	Past	Present	No		Past	Present	No		Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short of Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pains				Cough							
High Cholesterol				Wheezing							
Pace Maker											
Irregular Heartbeat				Eyes				Ear/Nose/Throat			
Swelling of Legs					Past	Present	No		Past	Present	No
				Glaucoma				Difficulty Swallowing			
				Double Vision				Dizziness			
Genitourinary				Blurred Vision				Hearing Loss			
	Past	Present	No					Sore Throat			
Kidney Disease				Psychiatric				Nosebleeds			
Burning Urination					Past	Present	No	Bleeding Gums			
Frequent Urination				Depression				Sinus Infection			
Blood in Urine				Anxiety							
Kidney Stones				Stress				Gastrointestinal			
Lower Side Pain									Past	Present	No
				Endocrine				Gall Bladder			
Neurologic					Past	Present	No	Bowel Problems			
	Past	Present	No	Thyroid				Constipation			
Stroke				Diabetes				Liver Problems			
Seizures				Hair Loss				Ulcers			
Head Injury				Menopause				Diarrhea			
Brain Aneurysm				Menstrual				Nausea			
Numbness								Vomiting			
Severe Headaches				Hematologic				Bloody Stool			
Pinched Nerves					Past	Present	No	Poor Appetite			
Parkinson's				Hepatitis				Musculoskeletal			
Carpal Tunnel				Blood Clots					Past	Present	No
Vertigo				Cancer				Gout			
				Bruising				Arthritis			
Constitutional				Bleeding				Joint Stiffness			
	Past	Present	No	Fever/Chills				Muscle Weakness			
Weight Loss				Sweating				Osteoporosis			
Weight Gain								Broken Bones			
Low Energy								Joint Replacement			
Female				Male							
	Past	Present	No		Past	Present	No				
Menstrual Irregularity				Prostate Problems							
Menstrual Cramping				Sexual Dysfunction							
Vaginal Pain/Infections											
Breast Pain/Lumps											

PATIENT INITIALS_____

DOCTOR INITIAL'S_____

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Name: _____ Date: _____

Patient Demographics:

Race: _____

Preferred Language: _____

Gender: _____Male _____Female

Ethnicity: _____

Preferred Contact Method: ___Phone ___Email ___Cell Phone Number: _____

Emergency Contact Information: Contact Name _____

Contact Number _____

Do you smoke? ___YES ___ NO If so, how much? _____

PLEASE DESCRIBE MEDICATIONS YOU ARE CURRENTLY TAKING:

(Name, Strength, Dose, Frequency, How is it taken, and date started)

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE DESCRIBE ALLERGIES YOU HAVE, THE REACTION, AND THE ONSET DATE:

1. _____
2. _____
3. _____
4. _____
5. _____

OFFICE USE ONLY

PATIENT VITALS:

Height: _____ Right Arm BP: _____/_____ Pulse: _____

Weight: _____ Left Arm BP: _____/_____

NAME:_____ **DATE:**_____

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Consent for Purposes of Treatment, Payment, and Health Operations

I consent to the use or disclosure of my protected health information by Fugate Family Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Fugate Family Chiropractic. I understand that diagnosis or treatment of me by Dr. Fairlena K. Fugate, DC or Dr. Joshua B. Bakun, DC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. Fugate Family Chiropractic is not required to agree to the restriction that I may request. However, if Fugate Family Chiropractic agrees to a restriction that I requested, the restriction is binding on Fugate Family Chiropractic and Dr. Fairlena K. Fugate, DC and Dr. Joshua B. Bakun, DC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Fairlena K. Fugate, DC and Dr. Joshua B. Bakun, DC or Fugate Family Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Fugate Family Chiropractic's Notice of Privacy Practices prior to signing this document. Fugate Family Chiropractic's Notice of Privacy Practices has been provided to me. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fugate Family Chiropractic. The Notice of Privacy Practices also describes the rights and Fugate Family Chiropractic's duties with respect to my protected health information.

Fugate Family Chiropractic reserves that 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 Representatives

_____
Name of Patient or Personal Representative

_____
Description of Personal Representatives Authority

_____
Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review that notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature (or Parent/Legal Guardian) Date

Our office, at the discretion of the Doctors, routinely discloses information such as, but not limited to, appointment time and date, account information (financial), and treatment information to family members (i.e.: spouse, parent, or sibling). Information of extremely private nature is never disclosed to anyone. Please indicate below should you wish information shared or restricted:

Share appointment information with spouse	_____ Yes	_____ No
Share appointment information with family members'	_____ Yes	_____ No
Share treatment information with spouse	_____ Yes	_____ No
Share treatment information with family members'	_____ Yes	_____ No
Share financial information with spouse	_____ Yes	_____ No

Other allowed disclosure or restriction: _____

_____ _____

Signature of Patient or Legal Guardian Date

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement for the following purposes:

Treatment: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain you consent after attempting to do so.

If there are substantial barriers to communicate and we determine, in the exercise or our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative, or another person responsible for your care or your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury, or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

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If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner, or funeral director.

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

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Right to Receive an Accounting. You have the right to receive an accounting of your disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made to our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice: You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

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

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms if this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

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Hazard, KY 41701

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

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Hazard, KY 41701
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Fax: (606) 487-9280