Welcome to Power Health Rehab & Wellness Center

Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential.

Patient Information

Today's date _____ Date of birth _____

Patient Name:_____

Last First MI

What Do You Prefer To Be Called:_____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Gender: ❑ Male ❑ Female Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Engaged

❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

How many children do you have? _____

Please list any family members being treated here _____

_____

Occupation _____

Employer/School _____

Employer/School phone number (_____) _____

Spouse's/Partner's name _____

Spouse's/Partner's employer _____

Who referred you? _____

For Office Use Only

Contact Information

Home phone (_____) _____

Cell phone (_____) _____

Email address _____

May we contact you via (please check for all applicable):

❑ Home phone ❑ Cell ❑ Work phone ❑ Email

In case of emergency please contact:

Name _____

Relationship _____

Home phone (_____) _____

Work/Other phone (_____) _____

Patient Condition

What is you major complaint *(be as specific as possible)* _____

_____

When did your condition/symptoms/pain first appear? *(specific date, days ago, weeks ago, etc)* _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Since the onset of your problem is it: ❑ Getting worse ❑ Staying the same ❑ Slow to improve

When is it worse? ❑ Morning ❑ Afternoon ❑ Evening

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily routines Other _____

Other doctors seen for this condition: ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other_____

Doctor's Name(s):_____ Primary Doctor:_____

Patient Condition

Does the condition/symptom/pain radiate? ❑ Yes ❑ No

If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: ❑ Numbness ❑ Tingling ❑ Weakness

Describe _____

List and mark the severity of your condition/symptoms/pain on the scales below:

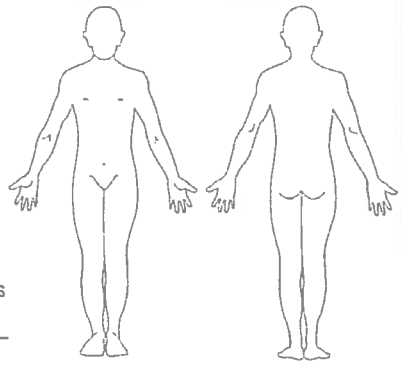
Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Type of Pain: ❑ sharp ❑ dull ❑ aching ❑ throbbing ❑ numbness ❑ shooting ❑ burning ❑ tingling ❑ Other _____

What activities or positions aggravate your condition?

❑ bending ❑ coughing ❑ getting up/down ❑ driving ❑ lifting ❑ lying down ❑ reaching ❑ sitting ❑ sneezing ❑ standing ❑ straining at stool ❑ turning head ❑ twisting ❑ walking Other _____

What activities or positions relieve your condition?

❑ heat ❑ ice ❑ lying down ❑ medication ❑ sitting ❑ standing ❑ stretching Other _____

Have you ever had this condition before? ❑ Yes ❑ No If yes, when? _____

Were you treated for this condition or a similar one before? ❑ Yes ❑ No If yes, when/by whom? _____

_____

Health History

Do you have any allergies? (food, contact, environment) _____

List any prescribed medications, over the counter medications, vitamins, herbs, and supplements _____

_____

When was your last: Physical examination? _____ Blood/lab work? _____ X-ray study? _____

Injuries/Surgeries you've had and when? _____

_____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Ankylosing spondylitis	❑ Yes	❑ No	Cushing's disease	❑ Yes	❑ No	Knee surgery	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Cystic medial necrosis	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Marfan syndrome	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Multiple sclerosis	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Digestive/Bowel problems	❑ Yes	❑ No	Osteoporosis/penia	❑ Yes	❑ No
Bowel/Bladder problems	❑ Yes	❑ No	Dizziness or vertigo	❑ Yes	❑ No	Parkinson's disease	❑ Yes	❑ No
Buzzing in ears	❑ Yes	❑ No	Fibromuscular dysplasia	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Rotator cuff problem	❑ Yes	❑ No
Carpal tunnel	❑ Yes	❑ No	Fusions (spinal, joint, etc)	❑ Yes	❑ No	STI/STD	❑ Yes	❑ No
Celiac disease (gluten)	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Shoulder surgery	❑ Yes	❑ No
Chest pains	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Spinal surgery	❑ Yes	❑ No
Chronic fatigue	❑ Yes	❑ No	Hepatitis (A, B, C, etc)	❑ Yes	❑ No	Stroke/TIA	❑ Yes	❑ No
Cold hands or feet	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Thyroid problems	❑ Yes	❑ No
Colitis/Diverticulitis	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Compression fractures	❑ Yes	❑ No	Hip replacement	❑ Yes	❑ No	Other _____		
Connective tissue issues	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Other _____		
COPD (bronchitis/emphy)	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Other _____		

Are there any conditions that run in your family? ❑ Yes ❑ No If yes, what condition(s) and which family members? _____

_____

Personal and Social Health History

How many hours per week do you typically work/attend school? ❑ <20 hrs ❑ 20 hrs ❑ 30 hrs ❑ 40 hrs ❑ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc)? _____

Do you exercise? ❑ Yes ❑ No If yes, how often and what type? _____

_____

How would you rate your eating habits? ❑ Excellent ❑ Pretty good ❑ Could be better ❑ Needs improvement

Do you follow a specific nutritional program? ❑ Yes ❑ No If yes, what type? _____

Would you like help with your diet or have a nutritional program developed for you? ❑ Yes ❑ No

Habits? ❑ Tobacco: Packs/Day _____ ❑ Alcohol: Drinks/Week _____ ❑ Caffeine: Cups/Ounces/Day _____

Other habits? _____

How well do you sleep? ❑ Excellent ❑ Pretty good ❑ Restless ❑ Can't Sleep

How many hours of sleep do you get daily? _____ *and* Do you feel well rested in the morning? ❑ Yes ❑ No

How is your energy overall? ❑ Full power ❑ Ok ❑ Low ❑ Sporadic/Generally fatigued

How do you feel your immune system is? ❑ Strong ❑ Ok ❑ Low

In your own words, what do you think chiropractors do? _____

What do you hope to receive from our program? _____

Other than the current condition(s) for which you are here today, are there any other conditions that you have that you would like to have checked by the doctor? ❑ Yes ❑ No If yes, describe? _____

Please add any comments here _____

For Women Only

Do you currently or have you ever used birth control? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long?

_____

Do you currently or have you ever taken hormone replacement medication? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long? _____

Are you currently pregnant, or do you think you may be pregnant? ❑ Yes ❑ No If yes, for how many weeks? _____

NOTICE OF PRIVACY PRACTICES

Effective Date: 4-14-2003

Last Revision Date: 6-1-2015

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.

This Notice serves as a notice for Power Health Chiropractic, Inc hereafter refered to as Power Health. We will follow the terms of this Notice and may share health information with each other for purposes of treatment, payment and health care operations as described in this Notice and as required under the Health Insurance Portability and Accountability Act of 1996. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 26, 2013. It applies to all protected health information (PHI) as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Power Health; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Power Health, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. Power Health maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. Power

Health may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.

- Amend your health record which you believe is not correct or complete. Power Health is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for Power Health; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by Power Health, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If we maintain your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but Power Health may charge you for additional lists within the same 12-month period. Power Health will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases Power Health is not required to agree to these additional restrictions, but if Power Health does, Power Health will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). Power Health must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

Power Health is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.

- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Kevin Anderson
Power Health Chiropractic, Inc
1175 Harvard Way
Reno, NV 89502

775-329-4402

If you believe your privacy rights have been violated, you can file a written complaint with Power Health's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

***Treatment*:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, Power Health operates an EMR. This is an electronic system that keeps PHI about you.

Power Health may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. Power Health may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself. Power Health may use a prescription hub which provides electronic access to your medication history. This will assist Power Health health care providers in understanding what other medications may have been prescribed for you by other providers.

***Payment*:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, Power Health that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

***Notification*:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication from Offices*:** We may call your home or other designated location and leave a message on voice mail, in reference to any items that assist Power Health in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist Power Health in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

***Communication with Family/Personal Friends*:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

***Open Treatment Areas*:** Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

***To Avert a Serious Threat to Health or Safety*:** We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. Power Health may use a single

***Workers Compensation*:** We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

***Law Enforcement*:** We may disclose PHI for law enforcement purposes as required by law.

***Inmates and Correctional Institutions*:** If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

***Lawsuits and Disputes*:** We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

***As Required by Law*:** We may use or disclose your PHI if we are required by law.

YOU WILL NOT BE PENALIZED OR RETALIATED AGAINST FOR FILING A COMPLAINT

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

***Coroners, Medical Examiners and Funeral Director*:** In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

***Deceased Individuals*:** In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

***Organ Procurement Organizations*:** Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Marketing*:** We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

***Sale of PHI*:** Power Health may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

***Food and Drug Administration (FDA)*:** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

***Public Health*:** As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

OUR FINANCIAL POLICY

Thank you for choosing **POWER HEALTH** as your health care provider. We are committed to providing the best treatment possible. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, or VISA/MC/AmEx/Discover

Regarding insurance:
We cannot bill your insurance company unless you provide us with a copy of your insurance card and personal identification.
After our billing office verifies coverage, we may accept assignment of insurance benefits, depending on policy information.
We do require all deductibles and co-payments to be made at time of service.
Your insurance policy is a contract between you and your insurance company. We are not party to that contract. If your insurance company has not paid your account in full within 45 days, you will be billed and expected to pay the balance in a timely fashion.
Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.
All charges incurred at the clinic remain your responsibility at all times.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients:
The adult accompanying a minor and the parent or guardian is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment at time of service has been verified.

Missed Appointments:
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest and returned checks:
We charge a $40.00 Fee for any checks returned by a bank.
For accounts over 30 days due, we reserve the right to charge interest in the amount of 1.5% per month as provided by State Law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Policy:

X_____Date_____
Signature of Patient or Responsible Party

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments, chiropractic spinal manipulative therapy, nutrition and supplement therapy or advisement, neuromuscular reeducation, other various modes of physiotherapy, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I have had the opportunity to discuss with the chiropractic physician and/or with other office personnel or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures that are within the chiropractic scope of practice. I understand that results are not guaranteed, there could be certain side effects associated with treatment, the benefits derived from some treatments may be reversed if treatment is discontinued, and I may terminate or suspend at any time and agree to notify this office of such actions. I also understand that the nature and purpose of evaluations and treatment may be considered medically unnecessary, experimental, not currently indicated, or unproven by scientific testing and peer-reviewed publications.

I understand and I am informed that, as in the practice of medicine and in healthcare, the practice of chiropractic carries some risks to treatment. These risks could include, but are not limited to: an aggravation of the condition, disc injuries, dislocations, fractures, sprains, strains, and stokes (CVA). I do not expect the physician to be able to anticipate and explain all risks and complications. I further wish to rely on the chiropractic physician to exercise judgment during the course of the procedure in which the chiropractic physician feels at the time, are in my best interest, based upon the facts then known. I attest that the information completed by me is correct and true to the best of my knowledge and agree to notify this office in the event of any change.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and reasonable alternatives to treatment, including leaving the condition as it is or seeking other medical advice. By signing below, I agree to the treatment recommended by the chiropractic physician. I intend this consent form to cover the entire course of my treatment(s) for my present condition(s) and any future condition(s) for which I seek treatment.

To be completed by the patient:

Patient's Name (Print)_____

Signature of Patient or Guardian_____

Guardian's Name (Print)_____

Date_____

POWER HEALTH AND WELLNESS

Description of Services
Included in special offers

To avoid any misunderstandings the following is an explanation of what is covered by our $79 First Visit Special:

Comprehensive Examination (value $95)
2 x-rays (if needed)
(Value $75.00 to $220.00, depending on views taken)

We offer these services to give you and us a chance to find out if our office can help you with your condition.

Any treatment or therapies provided will be charged at our regular fees.

I have read and understand the above mentioned description of the special introductory offer.

_____ _____

Name Date