

## 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? \_\_\_\_\_

### 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 (\_\_\_\_\_) \_\_\_\_\_

### For Office Use Only

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### Patient Condition

What is your 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: \_\_\_\_\_

## 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.*

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

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 \_\_\_\_\_

Please fill in the below area only if you are experiencing muscle, ligament, tendon, spinal or back pain

### 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

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 \_\_\_\_\_

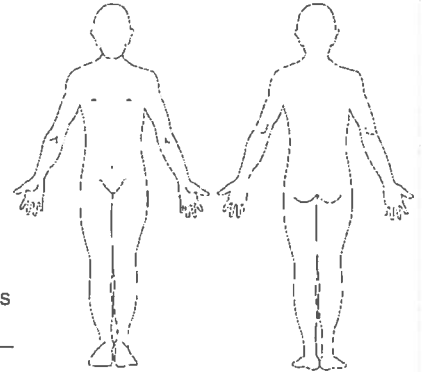
What activities or positions relieve your condition?

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? \_\_\_\_\_

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



## Informed Consent to 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 strokes (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 \_\_\_\_\_

**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**

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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.

# 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 referred 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

# 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