BEYER CHIROPRACTIC CENTER
CHIROPRACTIC · FUNCTIONAL NEUROLOGY · METABOLIC SOLUTIONS

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

PATIENT INFORMATION:

Patient Name_____ Today's Date: _____
Date of Birth_____ E-mail_____
Address: _____
Home Phone_____ Cell Phone: _____
Gender: Female_____ Male_____ Height_____ Weight_____
How many children do you have? _____ Any family members being treated here? _____
Occupation_____ Marital Status _____
In case of emergency please contact:
Name_____Relationship_____
Phone Number_____ Cell Phone_____
Spouse's/Partner's Name_____
Phone Number: _____Cell Phone_____

PATIENT CONDITION:
What is your major complaint (be as specific as possible)_____
_____
When did your condition(s) /symptoms/pain first appear? (Specific date, days ago, weeks ago, etc.)
_____
When is it worse? _____ Morning _____ Afternoon _____ Evening _____Varies in time of day
Does it interfere with: _____Work _____ Sleep _____Daily routines _____ Recreation_____ Other_____
How long has it been since you really felt good? _____
Other doctors seen for this condition _____MD _____DC_____DO_____DDS_____Other_____

Personal and Social Health History
Are you currently pregnant, or do you think you may be pregnant? ____Yes ___No If yes how many weeks? _____
How many hours per week do you typically work/attend school? _____
What are your typical duties and postures (sitting, standing, lifting, etc.)_____
_____
How would you rate your eating habits? ___Excellent___Pretty good___Could be better ___Needs improvement
How well do you sleep? ___Excellent ___Pretty good ___Restless___Cannot sleep ____Wake up often
How many hours of sleep do you get daily? ____Do you feel rested in the morning? ___Yes ____No
How is your energy overall? ____Excellent _____OK _____Low ____Sporadic/ Generally fatigued _____I depend on caffeine/ energy drinks for energy

How often do you get sick? ____Almost never ___I tend to catch what is going around_____I am constantly sick
What do you hope to achieve from our program?

_____

_____

HEALTH HISTORY

Do you have any allergies? (food, contact, environment)_____
List any vitamins, herbs and supplements_____
When was your last: Physical exam_____Blood/lab _____
X-ray study_____
Injuries/Surgeries you have had and when:

_____

_____

Have you had or do you have any of the following conditions or diseases? Please check any that apply to indicate yes.

__ADHD	__ Connective tissue issues	__HIV/AIDS	__Adrenal Disorder
__COPD	__Kidney Disease	__Anxiety	__Depression
__Knee Surgery	__Arthritis	__Diabetes	__Liver Disease
__Asthma	__Digestive/bowel problems	__Marfan's syndrome	__Autoimmune disorder
__Dizziness or vertigo	__Multiple sclerosis	__Bleeding disorder	__Ear Infection
__ Osteoporosis/penia	__Blurred vision	__Fibromyalgia	__Parkinson's disease
__Bowel/bladder problems	__Food Sensitivities	__Rotator Cuff problem	__Buzzing in ear
__Fusions (spinal/joint)	__STI/STD	__Gout	__Cancer (type)_____
__Shoulder injury	__Carpal Tunnel Syndrome	__Gall Bladder Issue	__Spinal injury
__Celiac disease (gluten)	__Immune compromise	__Stroke/TIA	__Heart Disease
__Tuberculosis	__Cold hands or feet	__Hepatitis (A,B,C,etc.)	__Colitis/diverticulitis
__High blood pressure	__Compression fractures	__Hip replacement	

__Other _____
__Other _____
Are there any conditions that run in your family? __Yes ___No If yes, what condition(s) and which family members?

_____

_____

_____

MEDICATIONS

Name: _____ Date: _____/_____/_____

List the name of each current prescribed and OTC (over-the-counter) medications, its prescribed use and any side effects/reactions/positive responses. (Example: birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (Example of side effect could be Tylenol caused liver enzymes to increase).

Medication	**The name of the condition or purpose for taking this medication.** (i.e. birth control pills for acne or endometriosis) Note: We do not need the number of pills or the dosage-mg/day info)	**Any Side-Effects**

PATIENT CONSENT FOR US AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/ or disclosures of my protected health information (PHI) necessary for the practice to provide me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a.) a postcard mailed to me at the address provided by me: and b.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for (7) seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

_____ _____

Name of Individual (PRINT NAME) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-in-Fact, Guardian, Parent if a minor): Relationship

Date Signed:_____/_____/_____ Witness: _____

Release of Information

You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at Beyer Chiropractic Center, P.C.

Right to Receive Payment

I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney, insurance company, or any other party who became obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I hereby instruct and direct my Insurance Company to pay by check made out and mailed directly to Beyer Chiropractic Center, P.C.

Assignment of Right to Sue

In the event any insurance company, attorney, or other person obligated to contractual agreement to make payment to me for your service charges, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, attorney, or person authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

Attorney Direction

I hereby direct my attorney not to interfere with or claim any lien upon medical payment benefits to which I may be entitled from whether my health insurance or medical payment sources. If any said medical payment check include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of Beyer Chiropractic Center, P.C.

_____ _____

Name of Individual (PRINT NAME) Signature of Individual

_____

Date

Beyer Chiropractic Center

PATIENT E-MAIL CONSENT FORM

Patient name: _____
E-mail: _____
Practice Physician: Dr. Stephen Beyer

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Stephen Beyer and Beyer Chiropractic Center so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
   Practice server could go down and E-mail would not be received until the server is back on-line.
i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.**
b) **If the patient's E-mail requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.**
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) **All E-mail will usually be printed and filed in the patient's medical record.**
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.

d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Beyer Chiropractic Center** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature_____
Date_____

Witness signature _____
Date _____

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