Weather Vane Chiropractic, P.C.

Patient Information

Personal Information

Full Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: ( ) __________ Cell Phone: ( ) __________

E-mail Address: ______________________________

Social Security Number or Government ID: ______________________________

Birth Date: __________ Marital Status: __________

Employer: __________ Work Phone: ( ) __________

Spouse's Name: ______________________________

Spouse's Employer: __________ Spouse's Work Phone: ( ) __________

Emergency Information

Full Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: ( ) __________ Cell Phone: ( ) __________

Relationship: ______________________________

Insurance Authorization

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical or government benefits to the Chiropractor(s) at Weather Vane Chiropractic for the service(s) which I receive at their office.

Patient Signature: ______________________________ Date: ____ / ____ / ____

Weather Vane Chiropractic, P.C.
120 Bustleton Pike, Churchville, PA 18966
215-322-1300 – Phone // 215-322-5301 – Fax

Patient Health History

MAIN COMPLAINT: Why are you here today? Be specific with location of pain.

____

____

When did it start? ____

How did it start? Explain ____

Work-related injury? Y ☐ N ☐ Auto Accident? Y ☐ N ☐ Injury at home? Y ☐ N ☐

Injury elsewhere? Y ☐ N ☐ Where? ____

Does it radiate down to any part of your body? Y ☐ N ☐ Where? ____________________

Did it begin gradually or suddenly? ____

How would you describe the intensity? (circle) Mild Moderate Severe

Describe your pain? (circle) Dull Sharp Burning Numbness Soreness Stiffness Other __________

Has the pain gotten: (circle) Better Worse Same

Does your condition come up suddenly or is it all the time?____________________

What makes your symptoms better? ____

What makes your symptoms worse? ____

Have you tried home remedies?____

What doctors have you seen and what tests have been done for your condition?

____

____

____

Past History

Have you ever had any of the following childhood diseases: (circle) Measles, Rubella, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, Other? ____________________

Have you ever been diagnosed with any other conditions? Y ☐ N ☐ Explain:

____

Are you presently under a doctor's care for any type of health problem? Y ☐ N ☐

Which Ones? ____________________

Have you had any broken bones? Y ☐ N ☐

Which ones and when? ____________________

Have you ever had any past significant auto accidents, work related injuries or falls? Y ☐ N ☐

When?____________________

Are you taking any medication(s)? Please list:

____

____

Have you ever undergone any type of surgery? Y ☐ N☐

What and When? ____________________

____

Do you smoke or drink? Y ☐ N ☐ Have you smoked in the past? Y ☐ N ☐ Drank? Y ☐ N ☐

If yes, how often? _________ For how long? _________ How many packs per day? _________

Do you use recreational drugs? Y ☐ N ☐ If yes, how often? ____________________

Do you have any allergies? Y ☐ N ☐ List:____________________

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU
HAVE HAD ANY OF THE FOLLOWING?

Y	N	Condition	Y	N	Condition
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 ☐	Stroke	Y ☐	N ☐	Blurred Vision
Y ☐	N ☐	Double Vision	Y ☐	N ☐	H.I.V.

HAVE YOU HAD ANY OF THESE FOLLOWING SYMPTOMS WITHIN THE LAST YEAR? IF YES, PLEASE DESCRIBE IN MARGIN.

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 or momentary blackouts
Y ❑ N ❑ Numbness or loss of sensation in the face, arms, fingers, or legs
Y ❑ N ❑ Any other abnormalities or loss of sensation in any other parts of your body
Y ❑ N ❑ Weakness, clumsiness, or strength loss in the face, arms, fingers, or legs
Y ❑ N ❑ Sudden collapse without loss of consciousness
Y ❑ N ❑ Diminished or partial loss of vision in one or both eyes
Y ❑ N ❑ Hearing loss in one or both ears

Men Only:

Date of last prostate exam ______________
Difficulty with urination? Y ❑ N ❑
Excessive urination? Y ❑ N ❑

Women Only:

Do you experience any of the following symptoms?
Menstrual pain? Y ❑ N ❑
Cramping? Y ❑ N ❑
Irregularity? Y ❑ N ❑

Do you take birth control pills? Y ❑ N ❑ For how long? __________
Date of your last period _________
Are you pregnant? Y ❑ N ❑ Not Sure ❑ If yes, how far along? _________

I hereby consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor and assign payment of medical benefits and authorize release of medical information in order to process claims.

Patient Signature ____________________________________ Date _________

FINANCIAL POLICY

Weather Vane Chiropractic, P.C
120 Bustleton Pike
Churchville, PA 18966

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, patients need to abide by the financial arrangements established for payment of your account.

- Payment is to be made at the time of visit unless prior arrangements have been made with this office. Also, a 24-hour notice is necessary to cancel an appointment. You may be responsible for payment of a missed appointment.

- Please note that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carrier remits payment, this includes deductibles and co-payments. If a problem occurs with your claim, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.

- Patient authorizes Weather Vane Chiropractic, PC to deposit checks received on patient's account when made out to the patient.

- If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

  Patient Name ____________________
  C/O Patient's name _______________
  120 Bustleton Pike, Churchville, PA 18966

  For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment.
  - A photocopy of this Assignment shall be considered as effective and valid as the original
  - I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
  - I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

If you have any questions concerning our policy or need assistance, please contact us immediately.

Date: ____________________________________

______________________________________ ______________________________
Signature of Insurance Member/ Parent or Guardian Witness

Weather Vane Chiropractic P.C.
120 Bustleton Pike, Churchville, PA 18966
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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.

This Notice explains how our office may collect, use and disclose your protected health information. It also explains your rights regarding your protected health information and the steps we take to keep your health information secure. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of care to you or the payment for that care.

Our office is required to provide you with this Notice by state and federal law. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. Our office is legally required to maintain the privacy of protected health information and to follow the privacy practices that are described in this Notice. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to all of the protected health information that we maintain, including any information we have created or received prior to issuing any new Notice. When we make an important change to our privacy policies, we will promptly change this Notice and post a new Notice in the office. You may also obtain any new Notice by asking for one at any time. This Notice goes into effect April 14, 2003.

Uses And Disclosures

Our office uses and discloses your protected health information for different reasons. We may collect and disclose protected health information from you and your other healthcare providers for the purposes of coordinating treatment, payment or operating your health care plan.

Treatment: We may use and disclose your protected health information to assist in your diagnosis and treatment. For example, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment: We may use and disclose your protected health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide your protected health information to our billing department and your health plan to get reimbursed for health care services. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that participate in claims payment process.

Health Care Operations: We may use and disclose your protected health information for activities necessary to operate your health care plan including quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, underwriting or determining premiums. We may also collect and disclose your protected health information as required by industry or government regulators such as the state licensing boards and insurance regulatory agencies.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes. As required, we may also disclose protected health information to the sponsor of your health plan (usually your employer). Our office must disclose protected health information about you when required by law. Examples of such disclosures include the following:

Avoid Threat to Health or Safety. We may disclose protected health information to law enforcement personnel or persons able to prevent or lessen a serious threat to the health or safety of a person or the public.

Coroners, Funeral Directors, Organ Donation. We may disclose protected health information to coroners, medical examiners, and funeral directors as is necessary for such persons to carry out their duties. Additionally, we may disclose protected health information relating to organ, eye, or tissue donations and transplants.

Health Oversight Activities. We may disclose protected health information to assist the government agencies for activities allowed or required by law such as when it conducts an investigation or inspection of a health care organization.

Health-Related Benefits or Services. We may disclose protected health information to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits that may be of interest to you.

Law Enforcement, Judicial and Administrative Proceedings. We may disclose protected health information when ordered to do so in a judicial or administrative hearing. We may disclose protected health information in response to a subpoena, discovery request or other lawful process. Finally, we may disclose protected health information in response to a warrant, to identify or locate a suspect, or to provide information about the victim of a crime.

National Security and Intelligence. We may disclose protected health information as required by military officials for national security and military intelligence purposes.

Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

Research. In certain circumstances, we may disclose protected health information in order to conduct medical research. Such circumstances include taking steps to protect your privacy.

Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence

Workers' Compensation. We may provide protected health information in order to comply with workers' compensation laws.

Authorization

Any uses or disclosures other than those described in above will be made only with the your prior written authorization, unless otherwise permitted or required by law. In the event you authorize us to use or disclose your protected health information in ways other than those described above, you have the right to revoke that authorization at any time by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right To Request Restrictions On Uses And Disclosures of Protected Health Information: You have the right to request restrictions on the use and disclosure of your protected health information. To request a restriction please speak to the Office Manager. Please note that while you may request a restriction, we have a right to refuse that request. If we accept your request, we will put the limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right To Receive Confidential Communications: You have the right to receive confidential communications, including the right to direct where communications containing protected health information are sent. For example, you may request that information be sent to your work address rather than your home address or via alternative means such as email rather than regular mail. To verify or modify where or how you would like such communications sent, contact the Office Manager. We will accommodate all reasonable requests. Unless requested otherwise, we will direct mailings and telephone messages containing protected health information to the address and telephone number we have on record for the subscriber of the health plan.

Right To Inspect And Copy Protected Health Information: In most cases, you have the right to see and get copies of your protected health information that we maintain. If you want to see or get copies of your protected health information you must submit your request in writing to the Office Manager. If we do not have your protected health information but know who does, we will tell you where you can get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do deny your request, we will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed. If you request copies of your protected health information, we will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance. Instead of providing the protected health information you requested, we may provide you with a summary or explanation of the protected health information as long as you agree to the summary and any applicable charges in advance.

Right To Amend Protected Health Information: If you believe that there is a mistake in your protected health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing to the Office Manager . We will respond within 60 days of receiving your request. We may deny your request in writing if the protected health information is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a rebuttal, you have the right to request that copies of your initial request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, inform you when the change is completed, and inform others that need to know about the change to your protected health information.

Patient Rights (continued)

Right To Receive An Accounting Of Disclosures Of Protected Health Information: You have a right to receive an accounting of any disclosures of your protected health information that were made for purposes other than coordinating treatment, payment or other health care services plan operations. The accounting will not include uses or disclosures made for treatment, payment, or health care operations, disclosures made directly to you or your family, or disclosures that you have already authorized. Additionally, the accounting will not include uses and disclosures made for national security purposes, or to corrections or law enforcement that has lawful custody over you. We will respond within 60 days of receiving your written request. The accounting will include the date of the disclosure, to whom protected health information was disclosed (including their address, if known), a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting you request within a 12-month period at no charge. For additional accountings within the same time period, we may charge you a fee for each additional request but will inform you of that fee in advance. To request an accounting of any such disclosures submit your request in writing to the Office Manager stating the time period for which you want the accounting. This time period may not be longer than six years and may not include dates before April 14, 2003.

Right To Get A Paper Copy Of This Notice: You have the right to get a paper copy of this Notice at any time even if you previously agreed to receive an electronic copy.
Right To File a Complaint. If you believe that your protected health information has been improperly used or disclosed, or that your privacy rights have been violated you may file a privacy complaint with us. To file such a complaint you should contact the Office Manager. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services (DHHS). We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having received a copy of this Notice of Privacy Practices.

Patient Name ____________________________

Signature ________________________ **Date of Signature** ________________

Relationship to Patient (if other than self) ________________________________

If this acknowledgement is being signed by a patient's legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.