Middleton Chiropractic

Patient Intake Forms

Name: _____ Date: _____/_____/_____

Address: _____ City _____

State: ____ Zip Code _____

Birthdate: _____ Age: _____ Sex: Male/Female

Cell # _____ Home #_____

Employer: _____ Occupation: _____

Work # _____

Please **circle** any and all insurance coverage that may be applied in this case:

Major Medical **Medicare** **Medicaid** **Auto** **Worker's Compensation**

Medical Savings Account & Flex Plans **Other :** _____

Name of primary insurance company: _____

Name of secondary insurance company (if any): _____

Consent for Disclosure of Personal Information

The following person(s) have my permission to receive my personal health information:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

In case of an emergency, we have your permission to contact:

Name: _____ Relationship: _____ Phone # _____

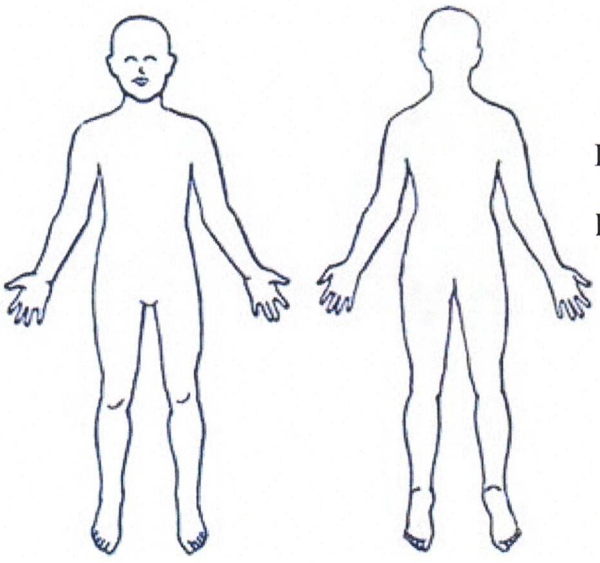
Name: _____ Relationship: _____ Phone # _____

Patient Signature: _____ Date: _____

Who may we thank for referring you to us? _____

Patient Name: Date:

What is the area of specific complaint? **Please mark an X on the picture where you are having pain, numbness, tingling or other.**



How and when did your symptoms start?

Is your pain: Constant Intermittent Other:

Describe the quality of pain. Circle all that apply.

Dull	Sharp	Aching
Burning	Shooting	Tightness
Stiffness	Tingling	Numbness

Other:_____

Does your pain radiate?

If so, where?

Has your condition: Circle all that apply.

Improved Worsened Stayed the same Exacerbated

What is affected by the pain you are having? Circle all that apply.

Daily routine Work routine Recreational routine Sleep

What activities of your daily living (ADL's) are most affected by your symptoms? Circle all that apply.

Bending over	Getting in/out of car	Lying down	Standing
Caring for family	Getting to sleep	Playing sports	Staying asleep
Climbing stairs	Grocery shopping	Reaching overhead	Using computer
Dressing self	Performing household chores	Rising out of chair/bed	Walking
Driving Car	Lifting objects	Showering/bathing	Working in yard
Exercising	Looking over shoulder	Sitting	Other:

How would you rate your pain on a scale from 0-10 with ten being the worst pain and one being the least? Circle one that applies.

0	1	2	3	4	5	6	7	8	9	10
No Pain					Noticeable Pain					Intense Pain

HEALTH HISTORY FORM

PATIENT NAME: _____ DATE: _____

What treatment have you already received for your condition? Please circle all that apply.

Medication Surgery Physical Therapy Chiropractic

Other_____

Date of last: Spinal Xray_____MRI_____Bone Scan_____

PLEASE **CIRCLE** ANY CONDITIONS THAT YOU CURRENTLY SUFFER FROM AND **CHECK** ANY THAT YOU PREVIOUSLY HAD

Arthritis	Depression	Blood Clots	Liver Disease	Tumors/Growths
Rheumatoid Arthritis	Dizziness	Heart Attack	Pancreatitis	Asthma
Osteoporosis	Epilepsy/Seizures	High Blood Pressure	Ulcer	COPD
Scoliosis	Headaches	High Cholesterol	Hernia	Emphysema
MS	Migraines	Pacemaker	Kidney Disease	Aids/HIV
Fibromyalgia	Parkinson's	Anemia	Diabetes	Hepatitis
TMJ Issues	Stroke	Crohn's Disease	Thyroid Disease	Chemical Dependency
Anxiety	Heart Disease	Acid Reflux	Cancer	Psychiatric Care
Anorexia/Bulimia	Other:			

Family History

Please circle all that apply.

Father	Mother
Arthritis/Osteo/Rheumatoid	Arthritis/Osteo/Rheumatoid
Cancer/Type:	Cancer/Type:
Diabetes	Diabetes
Heart Disease	Heart Disease
High Blood Pressure	High Blood Pressure
High Cholesterol	High Cholesterol
Thyroid Disease	Thyroid Disease

Do you exercise: None Moderate Daily Heavy

Do you smoke or chew tobacco: Yes No

Are you pregnant: Yes No

Please list all medications, vitamins and herbs that you currently take:_____

_____

_____

_____

_____

Falls:_____Date:_____

Head injuries/Whiplash:_____Date:_____

Motor Vehicle Accident/s:_____Date:_____

Fractures_____Date:_____

Dislocations:_____Date:_____

Surgeries:_____Date:_____

Patient Health Information Consent Form

AUTHORIZATION FOR PAYMENT

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Middleton Chiropractic, Inc. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Middleton Chiropractic, Inc. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Patient's Signature: _____ Date: _____

Guardian's Signature
Authorizing Care: _____ Date: _____

CONSENT FOR TREATMENT

Having voluntarily presented myself /or my dependent to Middleton Chiropractic, Inc. I acknowledge recognition of the fact that the evaluation and treatment received from Middleton Chiropractic, Inc. is advised and deemed necessary to be the judgment of the Physician.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form, you acknowledge that Middleton Chiropractic, Inc. has offered or given you a copy of its Privacy Notice, which explains how your health information will be handled. We must attempt to have you sign this form on your first date of service with us. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

I have received or read a copy of the Privacy Notice of Middleton Chiropractic, Inc. _____
Middleton Chiropractic, Inc. offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health info. _____

Signature: _____ Date: _____

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

Middleton Chiropractic, Inc. may disclose my medical information ONLY in my presence. _____
Middleton Chiropractic, Inc. may disclose my medical information when I am not present; this will include telephone calls, text, fax or mail. _____

****I understand that this consent may be revoked by me at any time by written notice to Middleton Chiropractic, Inc.** _____

Signature: _____ Date: _____

Witness Signature: _____ **Date:** _____

The staff of Middleton Chiropractic, Inc. should complete this section if Acknowledgement Form is not signed by the patient:

1. **Does the patient have a copy of the Privacy Notice? Yes _____ No _____**
2. **Please explain why the patient was unable to sign an Acknowledgement form and our efforts in trying to obtain the patient signature:** _____

Employee Signature _____ **Date** _____

Changes to this Notice of Privacy Practices

Middleton Chiropractic Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Middleton Chiropractic Inc. is required by law to comply with this Notice.

Middleton Chiropractic Inc. is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Complaints

Complaints about your Privacy rights, or how Middleton Chiropractic Inc. has handled your health information should be directed to Dr. Adam Middleton, by calling this office at 814-827-9970.

If Dr. Middleton is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

MIDDLETON CHIROPRACTIC

128 West Central Avenue
Titusville, PA 16354

Phone: 814-827-9970
Fax: 814-827-9971
E-mail: middychiro9970@yahoo.com
www.middletonchiro.com

MIDDLETON CHIROPRACTIC

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.

128 West Central Avenue
Titusville, PA 16354
814-827-9970

Disclosure of your Health Care Information

Treatment

We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example, we may ask you to have Radiology tests (such as X-rays or MRI), and we may use the results to help us reach a diagnosis.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Appointment Reminders

Our practice may use and disclose your health information to contact you and remind you of an appointment. This may include telephone reminders, postcards, letters or by email (unless you tell us that you do not want to receive these reminders).

Worker's Compensation/Auto Accident

We may disclose your health information as necessary to comply with State Workers' Compensation Laws and Auto Accidents.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your healthcare about your medical condition or in the event of an emergency or of your death.

Public Health Risks

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

Our practice may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Patients

Our practice may release your medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

Organ Donation

We may disclose your health information to organizations in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an International Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or reduce a serious threat to health and safety or the health and safety of another individual or the public.

Specialized Government Agencies

Our practice may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of ownership

In the event that Middleton Chiropractic Inc. is sold or merged with another organization, your health information/ record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon request.
- You have the right to read, review and copy your health information. We may need to charge you a reasonable fee to duplicate and assemble your copy.
- You have the right to request that Middleton Chiropractic Inc. amend your protected health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. Your request must be made to us in writing and you must describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are accurate and complete.
- You have a right to receive an accounting of disclosures of your protected health information made by Middleton Chiropractic Inc..
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.