**INTRODUCTION PATIENT CASE HISTORY**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient No:** \_\_\_\_\_\_\_\_\_\_\_ (*For office use only*)

**PATIENT INFORMATION**

**Name (First MI Last):**   **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender:** M/F

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A**

**Children & Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employed?**

❑ **Yes --** **Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ **No**

**Preferred method of communication for patient**

(Circle one): Email / Phone / Mail

**\*Who referred you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Status:** Non-Student / Full Student / Part Student

**Ethnicity**: Hispanic or Latino/ Not Hispanic or Latino /Decline

**Preferred Language:** English / Spanish / Other\_\_\_\_\_\_\_\_\_\_\_

**Race:** Asian / African Am / Am. Indian or Alaskan Native /

White / Native Hawaii or Pacific Island / Other/ Decline

**Smoking Status**: Every Day / Some Days / Former / Never

**Date Started**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Ended**\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship:** Child / Parent / Spouse / Other**: \_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL INFORMATION**

 Insurance  Self Pay (cash)  Personal Injury / Auto  Other (please explain)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is responsible for payment:** Self / Other – *(Relationship)* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Other than self:*

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_**

***It is Usual and Customary to Pay for Services as Rendered, Unless Otherwise Arranged***

**PATIENT CASE HISTORY**

**HISTORY OF CURRENT CONDITION**

**Describe Major Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Began When? \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Describe how this began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Grade Intensity/Severity of Complaint:** None / Mild / Moderate / Severe / Very Severe

**Quality of the complaint/pain**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How frequent is the complaint present?** Off & On / Constant

**Does this complaint radiate/shoot to any areas of your body? No / Yes** *(Describe)\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Head -* Base of Skull / Forehead / Sides-Temple R / L / Both *Leg -* Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

*Arm –* Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which daily activities (i.e. work) are being affected by this condition? (***Describe):****\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For this CURRENT condition, have you:**

• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

• **Had any previous Surgery or Interventions in this area?** *(Describe)***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

• **Taken any Medications?** OTC / Prescriptions *(list)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **When and Where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any Secondary Complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH HISTORY** *(please see reverse side of this page for additional space)*

***Medications:***

**Allergies to Medications: *NONE*** *(list****)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_**

**Current Medications & Dosage (or Pharmacy): *NONE*** *(list)*

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Past Health History:*** *(List)*

**Surgeries – Date, Type, and Reason: *NONE***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Major Injuries/Traumas: *NONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Major Hospitalizations: *NONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Family Health History:*** *(Mark N/A if not relevant.)*

**List *relevant* major family health problems:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deaths in immediate family:** *(Cause and Age)*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Social and Occupational History*:**

**Level of Education Completed:**

High School / Some College / College Grad / Post Grad / other

**Lifestyle:** *(Hobbies, Activities, Exercise, Diet, Work, Vitamins)*

**Habits:**

Cigarettes- *(#/day)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol- *(amount/day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Coffee/Tea – *(cups/day)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Rec. Drugs – *(List)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Are you *currently* experiencing any of these symptoms? *(Check all the apply)***

**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General:** *(constitutional)*

❑ Recent weight change

❑ Fever

❑ Fatigue

❑ *None in this category*

**Musculoskeletal:**

❑ Low back pain

❑ Mid-back pain

❑ Neck pain

❑ Arm problems **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Leg problems**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Painful joints

❑ Stiff/swollen joints

❑ Sore/weak muscles or joints

❑ Muscle spasms/cramps

❑ Broken bones

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ *None in this category*

**Neurological:**

❑ Numbness or tingling sensations

❑ Loss of feeling

❑ Dizziness or light headed

❑ Frequent or recurrent headaches

❑ Convulsions or seizures

❑ Tremors

❑ Stroke

❑ Head injury

❑ Ever been in an auto accident?

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Mind/Stress:**

❑ Nervousness

❑ Depression

❑ Sleep Problems

❑ Memory loss or confusion

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Genitourinary:**

❑ Sexual difficulty

❑ Kidney stones

❑ Burning/painful urination

❑ Change in force/strain w/urination

❑ Frequent urination

❑ Blood in urine

❑ Incontinence or bed wetting

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Gastrointestinal:**

❑Loss of appetite

❑ Blood in stool

❑ Change in bowel movements

❑ Painful bowel movements

❑ Nausea or vomiting

❑ Abdominal pain

❑ Frequent diarrhea

❑ Constipation

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Cardiovascular & Heart:**

❑ Chest pains

❑ Rapid or heartbeat changes

❑ Blood pressure problems

❑ Swelling: hands/ankles/feet

❑ Heart problems

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Respiratory:**

❑ Difficulty breathing

❑ Persistent cough

❑ Coughing blood

❑ Asthma or wheezing

❑ Lung Problems

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Eyes and Vision:**

❑ Wear contacts/glasses

❑ Blurred or double vision

❑ Glaucoma

❑ Eye disease or injury

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Ears, Nose and Throat:**

❑ Bleeding gums / mouth sores

❑ Bad breath or bad taste

❑ Dental problems

❑ Swollen throat or voice change

❑ Swollen glands in neck

❑ Ear Infections

❑ Ear – Ache / Ringing / Drainage

❑ Sinus / Allergy problems

❑ Nose Bleeds

❑ Hearing Loss

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Endocrine, Hematologic, and Lymphatic:**

❑ Thyroid problems

❑ Diabetes

❑ Excessive thirst or urination

❑ Cold extremities

❑ Heat or cold intolerance

❑ Change in hat or glove size

❑ Dry skin

❑ Glandular or hormone problem

❑ Swollen glands

❑ Anemia

❑ Easily bruise or bleed

❑ Phlebitis

❑ Transfusion

❑ Immune system disorder

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Skin and Breasts:**

❑ Rash or itching

❑ Change in skin color

❑ Change in hair or nails

❑ Non-healing sores

❑ Change of appearance of a mole

❑ Breast pain

❑ Breast lump

❑ Breast discharge

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

**Women Only:**

**Are you pregnant?**

❑ **Yes - Due date \_\_\_\_/\_\_\_\_/\_\_\_\_\_**

❑ **No -**  ***Last Menstrual Period***

***\_\_\_\_/\_\_\_\_/\_\_\_\_\_***

❑ Infertility

❑ Painful or Irregular periods

❑ Vaginal Discharge

❑ Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ *None in this category*

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMED CONSENT

**REGARDING:** Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Dohrmann Chiropractic & Acupuncture, P.C. will be explained to me, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

### By my signature below I am acknowledging that the doctor and/or a member of the staff will discuss with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

All forms of healthcare hold certain risks, including chiropractic. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, minor fractures and possible stroke, which occurs at a rate between one instances per one million to one per two million.

I choose to decline receipt of my clinical summary after every visit and understand I am legally inclined to receive a copy of my records at any time. Please note the clinical summary only includes the patient’s name and date for each visit. Again, you are welcome to request your records and charges for each visit at any time.

### I hereby authorize payment to be made directly to Dohrmann Chiropractic & Acupuncture, P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Dohrmann Chiropractic & Acupuncture, P.C. for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness Initial Patient or Authorized Person’s Signature Date

DOHRMANN CHIROPRACTIC & ACUPUNCTURE, P.C. NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

**PERMITTED DISCLOSURES:**

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes: To obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls or emails and appointment reminders: We may call your home and leave messages, email or text you regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. Change of ownership: In the event this practice is sold the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive detailed privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you, however you will be responsible for this cost.

I understand my rights as well as the practice’s duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practice” at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date