

**PATIENT INTRODUCTION CARD**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_ Phone (office): \_\_\_\_\_

D.O.B.: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: M F Your major complaint: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse: \_\_\_\_\_ Names and ages of children: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

Have you seen a Chiropractor previously?: Y N If yes, Chiropractor's name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Insured name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ Insured D.O.B.: \_\_\_/\_\_\_/\_\_\_ Relationship to Insured: \_\_\_\_\_

It is usual and customary to pay for services as rendered unless otherwise arranged.

# HEALTH ANALYSIS

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

*Please Circle the Appropriate Answer*

- |    |   |     |    |
|----|---|-----|----|
| 1  | Do you need glasses to read? .....                                      | Yes | No |
| 2  | Do you need glasses to see things at a distance? .....                  | Yes | No |
| 3  | Do your eyes continually blink or water? .....                          | Yes | No |
| 4  | Do you often have bad pains in your eyes? .....                         | Yes | No |
| 5  | Are your eyes often red or inflamed? .....                              | Yes | No |
| 6  | Are you hard of hearing? .....  | Yes | No |
| 7  | Have you ever had a fluid leaking from your ear? .....                  | Yes | No |
| 8  | Do you have constant noises in your ears? .....                         | Yes | No |
| 9  | Do you have to clear your throat constantly? .....                      | Yes | No |
| 10 | Do you often feel a choking lump in your throat? .....                  | Yes | No |
| 11 | Are you often troubled with bad spells of sneezing? .....               | Yes | No |
| 12 | Is your nose continually stuffed up? .....                              | Yes | No |
| 13 | Do you suffer from a constantly running nose? .....                     | Yes | No |
| 14 | Have you at times had bad nose bleeds? .....                            | Yes | No |
| 15 | Do you often catch severe colds? .....                                  | Yes | No |
| 16 | When you catch a cold, do you always have to go to bed? .....           | Yes | No |
| 17 | Do frequent colds keep you miserable all winter? .....                  | Yes | No |
| 18 | Do you get hay fever? .....   | Yes | No |
| 19 | Do you suffer from asthma? .....  | Yes | No |
| 20 | Are you troubled by constant coughing? .....                            | Yes | No |
| 21 | Do you wake up drenched with sweat during the middle of the night? ..   | Yes | No |
| 22 | Have you ever had a chronic chest condition? .....                      | Yes | No |
| 23 | Has a doctor ever said your blood pressure was too high? .....          | Yes | No |
| 24 | Has a doctor ever said your blood pressure was too low? .....           | Yes | No |
| 25 | Do you have pains in your heart or chest? .....                         | Yes | No |
| 26 | Do you often have difficulty in breathing? .....                        | Yes | No |
| 27 | Do you sometimes get out of breath just sitting still? .....            | Yes | No |
| 28 | Do you suffer from frequent cramps in your legs? .....                  | Yes | No |
| 29 | Has a doctor ever said you had heart trouble? .....                     | Yes | No |
| 30 | Does heart trouble run in your family? .....                            | Yes | No |
| 31 | Are your joints often painfully swollen? .....                          | Yes | No |
| 32 | Do your muscles and joints constantly feel stiff? .....                 | Yes | No |
| 33 | Do you have severe pains in the arms or legs often? .....               | Yes | No |
| 34 | Does arthritis run in your family? .....                                | Yes | No |
| 35 | Do weak or painful feet make your life miserable? .....                 | Yes | No |
| 36 | Do pains in the back make it hard for you to keep up with your work? .. | Yes | No |
| 37 | Do you have to get up every night and urinate? .....                    | Yes | No |
| 38 | During the day, do you usually have to urinate frequently? .....        | Yes | No |
| 39 | Do you often have severe burning when you urinate? .....                | Yes | No |
| 40 | Do you sometimes lose control of your bladder? .....                    | Yes | No |
| 41 | Has a doctor ever said you had kidney or bladder disease? .....         | Yes | No |

42	Do you suffer from frequent severe headaches? .....	Yes	No
43	Does pressure or pain in the head often make life miserable? .....	Yes	No
44	Are headaches common in your family? .....	Yes	No
45	Do you often have spells of severe dizziness? .....	Yes	No
46	Do you frequently feel faint? .....	Yes	No
47	Have you fainted more than twice in your life? .....	Yes	No
48	Do you have constant numbness or tingling in any part of your body? ..	Yes	No
49	Was any part of your body ever paralyzed? .....	Yes	No
50	Were you ever knocked unconscious? .....	Yes	No
51	Have you at times had a twitching of the head, face or shoulders? .....	Yes	No
52	Did you ever have a seizure or convulsion (epilepsy)? .....	Yes	No
53	Has anyone in your family ever had seizures or convulsion (epilepsy)?	Yes	No
54	Are you a sleep walker? .....	Yes	No
55	Are you a bed wetter? .....	Yes	No
56	Were you a bed wetter between the ages of 8 to 14? .....	Yes	No
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57	Are you often exhausted or fatigued? .....	Yes	No
58	Does working tire you out completely? .....	Yes	No
59	Do you usually get up tired or exhausted in the morning? .....	Yes	No
60	Does every little effort wear you out? .....	Yes	No
61	Are you constantly too tired and exhausted to even eat? .....	Yes	No
62	Do you suffer from severe nervous exhaustion? .....	Yes	No
63	Does nervous exhaustion run in your family? .....	Yes	No
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64	Are you frequently ill? .....	Yes	No
65	Are you frequently confined to bed by illness? .....	Yes	No
66	Are you always in poor health? .....	Yes	No
67	Are you considered a sickly person? .....	Yes	No
68	Do you come from a sickly family? .....	Yes	No
69	Does severe pain make it impossible for you to do your work? .....	Yes	No
70	Do you wear yourself out worrying about work? .....	Yes	No
71	Are you always ill and unhappy? .....	Yes	No
72	Are you constantly made miserable by poor health? .....	Yes	No

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I have read Dr. Karen's Notice of Privacy Practices.

Patient Name: \_\_\_\_\_  
(Please print name)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Must be at least 18 years of age)

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient

## DR. KAREN'S OFFICE POLICY

**Patient Name** \_\_\_\_\_

**OFFICE:** We believe that a clear definition of our office policies will allow us to concentrate on "The Big Issue" **REGAINING AND MAINTAINING YOUR HEALTH.** It is the goal of our office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know.

**Initials** \_\_\_\_\_ **AUTHORIZATION FOR PAYMENT:** It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us.

1. The privilege of insurance assignment begins when our office receives your insurance forms and coverage has been verified.
2. If filing insurance, I hereby authorize Dr. Karen to furnish any and all medical records that my insurance company may request for payment of my charges.
3. If I am choosing not to file insurance, I understand that I am expected to make payment at the time of service and agree to make payment in accordance with this policy.

**Initials** \_\_\_\_\_ **PHONE CONTACT:** Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, follow thru medical information, treatment alternatives, or other health related information. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By initialing you are giving us authorization to contact you and to leave messages on your answering machine or with individuals at your home or place of employment.

**Initials** \_\_\_\_\_ **INFORMED CONSENT:** The patient has been informed and understands that the practice of chiropractic includes treatment by manipulation of the patient's body, including the spine. Manipulation of the body and the spine necessarily involves applying pressure, by the use of "hands on" techniques which require Dr. Karen to use her hands and body to cause appropriate movement within the patient's body. Manipulation by a chiropractor should not cause damage to the patient. Manipulation of the patient by the chiropractor will necessarily involve physical contact between Dr. Karen and the patient. The patient acknowledges that the general nature of this physical contact has been explained to them by Dr. Karen prior to commencement of treatment and examination. During treatment Dr. Karen may touch the patient's body in a variety of areas including near the patient's groin, the patient's buttock, and near the patient's breasts. If the patient feels that such potential for contact may be distressing or uncomfortable the patient should either avoid chiropractic treatment with this chiropractor or, in writing request that an attendant observer be present during treatment and examination, subject to any applicable charge. If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs, you will immediately inform Dr. Karen and give her sufficient notice to allow her to alter the treatment plan as appropriate.

**Initials** \_\_\_\_\_ **THANK YOU CARDS:** If you refer a friend, family member or colleague to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a thank you card.

**Initials** \_\_\_\_\_ **REFERRAL BOARD:** If you refer a friend, family member or colleague to our office, we would like to put your first name **ONLY** on our referral board, thanking you for sending that person to our office. By signing this form you are giving us authorization to display your name on our board.

**Initials** \_\_\_\_\_ **FINANCIAL ARRANGEMENTS:** We have an open front desk and many of our financial arrangements are discussed at the front counter. Please do not initial this if you would prefer to have your financial arrangements discussed in a more private place.

I have read and fully understand all of the above information. I acknowledge that I have read or received a copy of Dr. Karen's Notice of Privacy Practices. I also understand that my refusing to sign this form means that I will not be treated at this office.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian's Signature Authorizing Care for Minor** \_\_\_\_\_

## 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.**

Dr. Karen's Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at the office please contact the office at (405) 330-8745.

### **I. How Dr. Karen's Wellness Center may Use or Disclose Your Health Information**

Dr. Karen's Wellness Center collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Dr. Karen's Wellness Center, but the information in the medical record belongs to you. Dr. Karen's Wellness Center protects the privacy of your health information. The law permits Dr. Karen's Wellness Center to use or disclose your health information for the following purposes:

1. Treatment. We may disclose information regarding your treatment to other health care providers who have requested information pertaining to your treatment.
2. Payment. In the event that your health insurance company should need specific information regarding your health care in order to issue payment, we will provide the information to the entity issuing the request.
3. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
4. Required by law. As required by law, we may use and disclose your health information.
5. Public health. 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 Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
6. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
7. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
8. 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.
9. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
10. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
11. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

13. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services.
14. Change of Ownership. In the event that Dr. Karen's Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

## **II. When Dr. Karen's Wellness Center May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, Dr. Karen's Wellness Center will not use or disclose your health information without your written authorization. If you do authorize Dr. Karen's Wellness Center to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **III. Your Health Information Rights**

1. You have the right to request restrictions on certain uses and disclosures of your health information. Dr. Karen's Wellness Center is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that Dr. Karen's Wellness Center amend your health information that is incorrect or incomplete. Dr. Karen's Wellness Center is not required to change your health information and will provide you with information about Dr. Karen's Wellness Center's denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by Dr. Karen's Wellness Center, except that Dr. Karen's Wellness Center does not have to account for the disclosures described in parts 1 (treatment) and 2 (payment) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Dr. Karen's Wellness Center 134 East 15<sup>th</sup> Street Edmond, OK 73013.

## **IV. Changes to this Notice of Privacy Practices**

Dr. Karen's Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Dr. Karen's Wellness Center is required by law to comply with this Notice. In the event that this notice is changed a copy of the revised version will be mailed to the address we have on file.

## **V. Complaints**

Complaints about this Notice of Privacy Practices or how Dr. Karen's Wellness Center handles your health information should be directed to Dr. Karen's Wellness Center 134 East 15<sup>th</sup> Street Edmond, OK 73013.

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

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at <http://www.hhs.gov/ocr/regmail.html>