Harvard Square Chiropractic
Therapeutic Health Center

Today's Date: _____

Harvard Square Chiropractic

Patient Information

Name _____
(First) (Middle) (Last)

Address _____ City/State/Zip _____

Date of Birth _____ Male ____ Female ____ Other ____

Occupation _____ Employer _____

Spouse's Name _____ Policy Holder's Name _____

How did you hear about us? GOOGLE YELP OTHER REFERRAL

Contact Information

Home Phone _____ Cell Phone _____ Work _____

Appointment reminder via email (circle one) YES NO Email _____

Best way to reach you (circle one) HOME CELL WORK EMAIL DO NOT CALL

In Case of Emergency Contact:

Name _____ Relationship _____ Phone _____

Accident Information

Is your condition due to an accident (circle one) YES NO If yes, date of accident _____

Type of accident (circle one) AUTO WORK HOME OTHER _____

To whom have you reported the accident (circle one) INSURANCE WORKER'S COMP. EMPLOYER OTHER

Patient Condition

What is your major symptom/problem? _____

When and how did your symptoms begin? _____

Have you had this problem before? _____

What makes your condition better? _____ Worse? _____

Is your condition getting progressively worse? _____

Is your condition constant or does it come and go? _____

How does it feel? BURNING SHARP DULL ACHING STIFF TINGLING THROBBING SWELLING OTHER

Circle the severity of your pain on a scale: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

Health History

What other treatments have you had for this condition? (circle one)

CHIROPRACTIC ORTHOPEDIC NEUROLOGIST PHYSICAL THERAPY MEDICATION

Name of other Doctors who have treated you for this condition _____

Previous Chiropractic care? (circle one) YES NO Date _____ LOCAL OUT OF STATE

Intake continued on to next page

Date of last:

Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____

Dental X-Ray _____ MRI _____ CT-Scan

_____

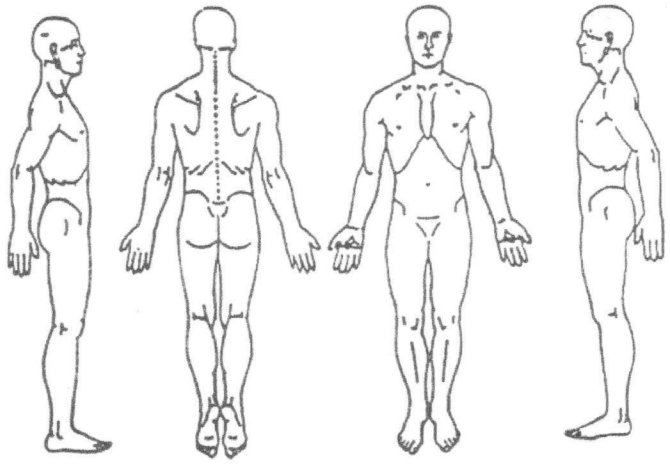
List of any medications you are taking _____

_____

Surgical History _____

Females: Are you pregnant? (circle one) YES NO

Circle/Mark/Indicate areas of past and current Pain and Injury:



Put a check by all conditions that you have had, past or present:

_____ AIDS/HIV	_____ earache	_____ neck pain
_____ allergies	_____ ear ringing	_____ osteoporosis
_____ anxiety	_____ epilepsy	_____ poor circulation
_____ arm/shoulder pain	_____ headaches	_____ prostate problems
_____ arthritis	_____ headaches-migraine	_____ rheumatoid arthritis
_____ asthma	_____ hemorrhoids	_____ sciatica
_____ bladder problems	_____ herniated disk	_____ shingles
_____ cancer	_____ high blood pressure	_____ sinus infection
_____ chronic fatigue	_____ insomnia	_____ stroke
_____ deafness	_____ irregular cycle	_____ thyroid problems

_____ depression	_____ kidney problems	_____ TMJ
_____ diabetes	_____ leg pain	_____ venereal disease
_____digestive problems	_____ lower back pain	_____ vertigo/dizziness

Intake continued on to next page

Stressors

Smoking	Packs/Day _____
Alcohol	Drink/Week _____
Caffeine	Cups/Day _____
High Stress Level	Reason _____

Exercise Level (circle one)

None

Moderate

Daily

Heavy

Authorization

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance, including deductibles and copayments. I authorize Harvard Square Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient Signature Date Parent Signature (if patient is a minor)

Harvard Square Chiropractic
Therapeutic Health Center

Waiver

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me (or the patient named below, /or whom I am legally responsible) by the doctor of chiropractic, Patrick Doody D.C., and/or the licensed doctors of the chiropractic who now or in the future work at the clinic of office listed below or any other office or clinic.

I have had the opportunity to discuss with Patrick Doody D.C. and/or with other or clinic personnel the nature and purpose of chiropractic adjustments and other procedures, and I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above-name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient (or personal representative) Date

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters the concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use of dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health information of Harvard Square Chiropractic.

_____ _____

Patient (or personal representative) Date

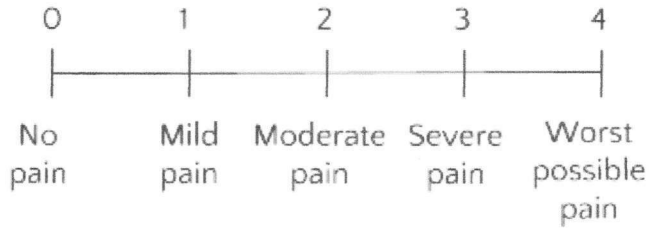
Functional Rating Index

For use with neck and/or back problems only

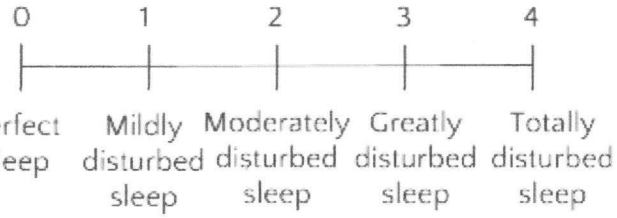
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now

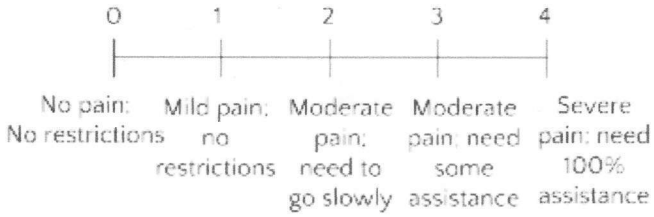
1. Pain Intensity



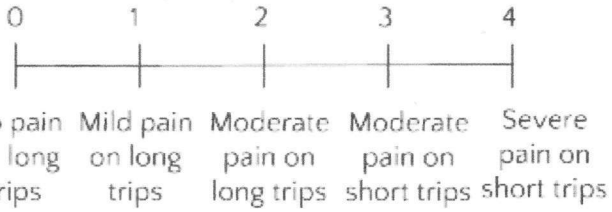
2. Sleeping



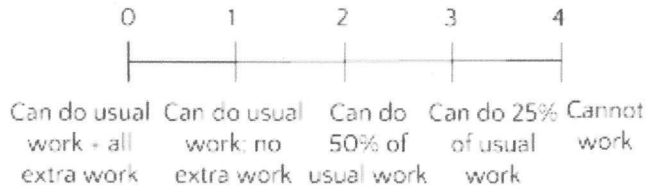
3. Personal Care



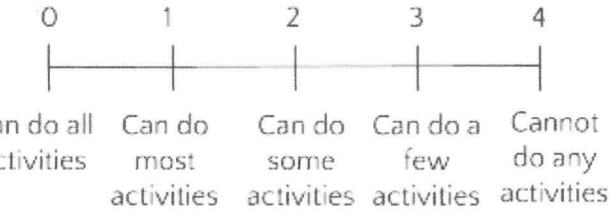
4. Travel (driving, etc.)



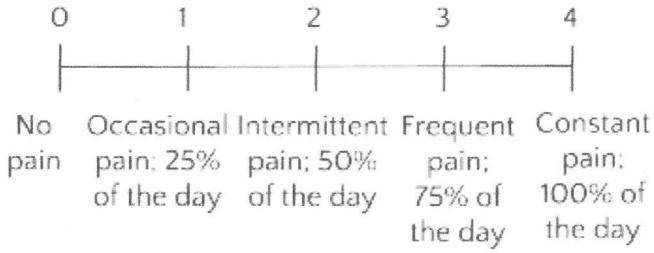
5. Work



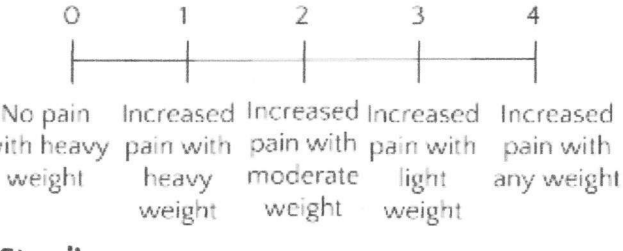
6. Recreation



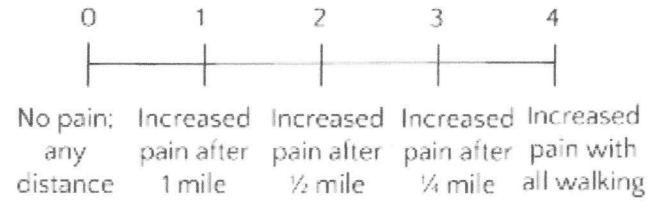
7. Frequency of pain



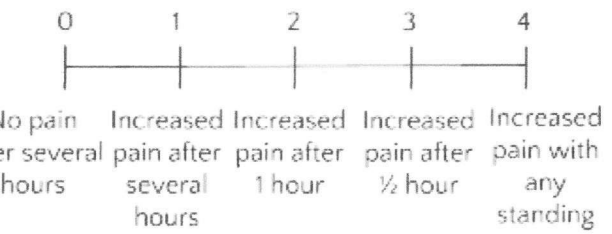
8. Lifting



9. Walking



10. Standing



Name _____

Signature _____

____ Total Score

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.164.508(b)(5)(i)
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at

Harvard Square Chiropractic

15 Story St.

Cambridge, MA 02138

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Tricia Butler, Office Maneger

15 Story St.

Cambridge, MA 02138

To contact us

If you would like further information about our privacy policies and practices please contact:

Harvard Square Chiropractic

15 Story St.

Cambridge, MA 02138

617-441-0101

This notice is effective as of Nov. 1st, 2010, or the date you first signed the acknowledgement of receipt of this notice. This notice expires seven years after the date upon which your record was created, which is seven years after the last date of service.