Living with Motion Chiropractic

Keeping families young, for years to come!

PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION. THANK YOU.

Name: _____ Date: _____ Acct. #: _____

How did you hear about our office? ☐ CBYP online ☐ Sign ☐ Google ☐ Yahoo ☐ Church Bulletin ☐ Patient

☐ Other _____

If referred by a friend or patient, whom may we thank for their kind referral? _____

• All information is kept STRICTLY CONFIDENTIAL. Please complete as accurately as possible. •

• ABOUT YOU • ☐ Check if same as Driver's License

Full Name: _____ **Email Address:** _____

Prefer to be called: _____ **Home Telephone:** (____) _____ - _____

Address: _____ **Mobile Phone**: (____) _____ - _____

_____ **Employer/Occupation:** _____

City: _____

State: _____ **ZIP:** _____ **Marital Status:** ☐ **Single** ☐ **Separated** ☐ **Divorced**

Date of Birth: ____ / ____ / _____ **Age:** _____ ☐ **Married** ☐ **Widowed**

• MEDICAL / HEALTH CARE HISTORY •

Please list any prescriptions, over-the-counter (OTC) medications or supplements you are presently taking: _____

_____

_____

What health challenges are you facing creating the need for medication? _____

_____

Please list any illnesses, accidents, surgeries and/or treatments with dates: _____

_____

PRIMARY INSURANCE

Policy Holder's Name: _____ Policy Holder's DOB: _____

Ins. Co. Name: _____ Policy ID #: _____ Group #: _____

• EMERGENCY CONTACT •

Name: _____ Relationship: _____

Telephone: (_ ____) _____ - _____ Alternate Telephone: (_____) _____ - _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been to a chiropractor before? ☐ No ☐ Yes If "Yes", when? _____
2. Have you ever seen another Doctor for this problem? ☐ No ☐ Yes If "Yes", when? _____
3. Were you ever injured in an automobile accident either as a passenger or the driver? ☐ No ☐ Yes If "Yes", when? _____
4. Were you ever injured at work or as the result of employment? ☐ No ☐ Yes If "Yes", when? _____

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PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION. THANK YOU.

Name: _____ Date: _____

Tell us about your delivery and birth of this child:_____
_____ _____

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____
Did you have a C-Section? _____ Were forceps used? _____
Vacuum Extraction? _____ Were you induced? _____
Did you have an Epidural? _____ Was it a difficult birth? _____

As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in a jumper
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____
_____
_____

As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____
_____
_____

Nutritional Intake:

Is your child picky with veggies and kinds of proteins?_____

How many processed meals does your child consume a week? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Does your child have any known food allergies?_____

Does your child consume water and how much?_____ How often do they drink soda/juice?_____

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PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION. THANK YOU.

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.

Living with Motion Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSER OF YOUR HEALTH INFORMATION

- **Treatment - We may disclose your protected health information to doctors, hospitals, and other healthcare professionals for their provision, coordination, or management of your health care and related services.**
- **Payment - We may disclose your protected health information to insurance providers for the purpose of payment or healthcare operations.**
- Workers' Compensation - We may disclose your protected health information to comply with State Workers' Compensation Laws.
- Emergencies - We may disclose your protected health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
- Public Health - As required by law, we may disclose your protected 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.
- Judicial and Administrative Proceedings - We may disclose your protected health information in the course of any administrative or judicial proceeding or in response to a legal order.
- Law Enforcement - We may disclose your protected health information to law enforcement officials 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 Persons - We may need to disclose your protected health information to coroners or medical examiners.
- Organ Donation - We may need to disclose your protected health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- Research - We may need to disclose your protected health information to researchers conducting research that has been approved by an institutional Review Board.
- Public Safety - It may be necessary to disclose your protected 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.
- Specialized Government Agencies - We may disclose your protected health information for military, national security, prisoner and government benefits purposes.
- Marketing - We may contact you for marketing purposes or fundraising purposes. We may call you at home to confirm your appointments and may leave a message if there is no answer or you are not available. No protected health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.
- Referrals – We may acknowledge and express appreciation to a patient, physician, or other person who has referred you to Living with Motion Chiropractic for care. No protected health information will be disclosed other than your identity as it is known to the person referring you.
- Change of Ownership - In the event that Living with Motion Chiropractic is sold or merges, your protected health information / record will become the property of the new owner.

YOUR INDIVIDUAL RIGHTS

- Your Protected Health Information Rights - You have the right to request restrictions on certain uses and disclosures of your protected health information. Living with Motion Chiropractic is not required to agree to the restriction. You have the right to have your protected health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your protected health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.
- Changes to this Notice of Privacy Practices – Living with Motion Chiropractic reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information, contact Dr. Lucas Reineck at 513-831-4433.
- Complaints - Complaints about how Living with Motion Chiropractic has handled your health information should be directed towards Dr. Lucas Reineck at 513-831-4433. 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 Ave., S.W.; Room 509F; HHH Building; Washington D.C. 20201.

ADDITIONAL INFORMATION

- Treatment - This office uses open room adjusting and therapy. Per request we will accommodate you to a closed room for adjusting and therapy.

This notice is effective as of Nov 1, 2008.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature I provide Living with Motion Chiropractic with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in this notice. The staff of Living with Motion Chiropractic has explained the Notice of Privacy Practices to my satisfaction. I am aware that Living with Motion Chiropractic has the right to change the terms of its notice and make any provisions effective for all the protected health information that it maintains.

_____
Patient's Name (PRINT)

_____ _____ _____ _____
Patient's Signature Date Authorized Facility Signature Date

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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Living with Motion Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is currently no charge for missed appointments however it's important that you adhere to your care plan to achieve the best results.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____