Legacy Chiropractic

CONTACT INFORMATION:

Date _____

Name _____ Preferred Name/Nickname: _____

DOB ____/____/____ AGE _____ Do you Have Medicare ☐ Yes ☐ No

Cell Phone _____ Phone (Home or Work) _____

Addres_____

Number & Street Apt # City State Zip

Primary Email Address _____

Preferred Contact Method: ☐ Email ☐ Phone

Emergency Contact: _____ Phone_____

☐ Single ☐ Married/Partnered Spouse's Name_____

# of Children _____ How many at home? _____

Names & ages: _____

Employed? ☐ Yes ☐ No Profession and Employer? _____

Do you have insurance? ☐ Yes ☐ No If yes, what carrier? _____

Name of Primary Care Provider/Practice? _____

Which holistic practitioners? _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit

____/____/____

If yes, how long did you receive care? _____

Have you ever been told you have any issues in your spine or nerve system?

☐ Yes ☐No If yes, what? _____

Whom may we thank for referring you to Dr. Ballam?

_____

If not through a personal or MD referral, how did you find Legacy Chiropractic?

_____

201 Davis Grove Circle Suite 106. Cary, NC 27519
www.LegacyChiropracticNC.com
P: 919-363-2277 E: Office@LegacyChiropracticNC.com

Legacy Chiropractic

CURRENT HEALTH HISTORY:

ADDRESSING THE ISSUES THAT BRING YOU TO LEGACY CHIROPRACTIC

Why are you looking to receive care? _____

_____

_____

_____

_____

On a scale of 0-10 how bad is your top concern (10 being the worst)

(ZERO) 0 ←——— 5 ———→ 10 (MAX)

Is this problem related to a **Work Injury**? ☐ Yes ☐ No **Auto Accident**? ☐ Yes ☐ No

How long have you had this problem? _____

Do you know what caused this problem? _____

What seems to make this problem better? _____

What seems to make this problem worse? _____

What Providers have you seen for this issue?

Emergency/Urgent Care: _____ Results: _____

Primary Doctor: _____ Results: _____

Massage Therapist: _____ Results: _____

Other Chiropractor: _____ Results: _____

What activities of your daily life has this impacted? _____

_____

_____

Is there anything not included on this form that you feel the Doctor should know? _____

_____

_____

CURRENT MEDICATIONS/SUPPLEMENTS (prescription and over the counter)

Medication: _____ Reason: _____

For how long? _____

Medication: _____ Reason: _____

For how long? _____

Medication: _____ Reason: _____

For how long? _____

Medication: _____ Reason: _____

For how long? _____

Medication: _____ Reason: _____

For how long? _____

Legacy Chiropractic

SYMPTOM CHECKER: **(✓)** CURRENT CONDITIONS **(X)** PAST CONDITIONS

NMS:

- □ Headaches
- □ Light bothers eyes
- □ Jaw pain / TMJ
- □ Neck Stiffness
- □ Neck Pain
- □ Pins & Needles in arms
- □ Numbness in arms/ hands
- □ Cold hands
- □ Arthritis
- □ Mid back pain
- □ Scoliosis
- □ Low back pain
- □ Disc herniation
- □ Pins and needles in legs
- □ Numbness in legs/ feet
- □ Cold feet
- □ Ankle Swelling
- □ Paralysis
- □ Cold Sweats
- □ Multiple Sclerosis
- □ Parkinson's
- □ Fibromyalgia

Visceral:

- □ Stroke
- □ Sinus Problem
- □ Allergies
- □ Excessive Thirst
- □ Thyroid Problems
- □ Chest Pain
- □ Heart Disease
- □ Irregular Heartbeat
- □ heart Attack
- □ Asthma
- □ Difficulty Breathing
- □ Lung Problems
- □ Acid Reflux/ heartburn
- □ Loss of appetite
- □ Weight Loss
- □ Upset stomach
- □ Ulcers
- □ Liver disease
- □ Kidney disease
- □ Diabetes
- □ Anemia
- □ Problems urinating
- □ Painful urinating
- □ Excessive urination
- □ Constipation
- □ Diarrhea
- □ Colitis
- □ Irritable Bowel
- □ Hemorrhoids
- □ Prostate problems
- □ Infertility
- □ Fever

Female:

- □ Pregnancy
- □ Nursing
- □ Difficulty getting pregnant
- □ Miscarriage
- □ Menstrual Pain
- □ Menstrual Irregularities
- □ Hot Flashes

Other:

- □ Cancer
- □ Loss of sleep
- □ Oversleeping
- □ Low Energy
- □ Confusion
- □ Tension
- □ Mood Swings
- □ Depression
- □ Irritability
- □ Nervousness
- □ Anxiety

Special Senses:

- □ Loss of smell
- □ Loss of taste
- □ Loss of hearing
- □ Blurred vision
- □ Ringing in ears
- □ Loss of balance
- □ Dizziness
- □ Fainting
- □ Epilepsy
- □ Other_____

_____

_____

The statements made on this history form are accurate to the best of my recollection.

Signature: _____ Date: ___/___/___

Legacy Chiropractic

Acknowledgment of "NOTICE OF PATIENT PRIVACY POLICY"

Patient Name: _____

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we are required to supply you with a copy of our privacy policy 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 have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have received a copy of the "NOTICE OF PATIENT PRIVACY POLICY" document for *Legacy Chiropractic*.

Signature_____ Date: _____

I give Legacy Chiropractic permission to contact my primary care provider regarding my care plan and progress. Initials: _____

Is there anyone else that you would like to give authorization for us to share your information with? (I.e. spouse, partner, family member)

Name_____

Relationship_____

Name_____

Relationship_____

Name_____

Relationship_____

Legacy Chiropractic

Patient Consent to X-ray:

If necessary, I authorize Legacy Chiropractic to perform x-rays of myself for diagnostic and treatment purposes.

Signed: _____ Date: _____

FEMALES: Regarding Possibility of Pregnancy

I certify that, to the best of my knowledge I am **NOT PREGNANT**, and Legacy Chiropractic has permission to perform diagnostic x-ray examination. It is not advisable to receive x-ray particularly those involving the pelvis on pregnant women. X-rays may be hazardous to an unborn child.

Initials: _____

Legacy Chiropractic

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Legacy Chiropractic

NOTICE OF PATIENT PRIVACY POLICY

Our Privacy Pledge

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

Your Right to Receive Confidential Communication

We normally provide information about your health to you in person at the time you receive services. 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 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

You have the right to inspect and /or copy your health information for seven years form 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.

Your Right to Amend

You have the right to request we amend your health information for seven years form the date 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 with a reason to support the change you are requesting us to make.

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.

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 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 run our practice efficiently and effectively.
4. Your chiropractor and members of the practice staff may need to use your name, address, and phone number and your clinical records to contact you to provide appointment, reminders, information about health alternatives, or other health related information that may be of interest to you. 164.520(b)(l) (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 health alternatives, or other health related information. If you do not give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care. You have the right to inspect or copy the information that we use to contact you to provide appointment reminders or any other health related information at any time.

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 our office address.

Other Permitted Uses and Disclosures without 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. If we are providing health care services to you based on the orders of another health care provider.
2 If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the examples above and in the ***Uses and Disclosures*** section of this notice, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Receive an Accounting of Disclosures made of your Records

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

1. Required for treatment, to obtain payment for services, or to run our practice.
2. Made to you or those involved in your care.
3. Necessary to maintain a directory of the individuals in our facility.
4. For national security or intelligence purposes, as required by law.
5. Made to correctional officers or law enforcement officers as required by law.
6. That were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within a 12-month period without charge. There will be a fee of $10 for any additional requests during the next 12 months.

Your Right to Limit 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, to whom you do not want us to disclose your health care information. We are not required to agree to 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.

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 the office for your appointment 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.

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 actions against you if you do so. While you may make an oral complaint at any time, written comments should be addressed to Dr. John Ballam at our office address shown on this document.

To Contact Us

If you would like further information regarding our privacy policies and practices, please contact our office.

This notice is effective 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.