STEPHENSON CHIROPRACTIC

Dr. Jason D. Stephenson & Dr. Kimberly Stephenson

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256.773.1113

stephensonchiropractic.net

CASE HISTORY

*Name: _____ Today's Date: _____
*Sex: Male ___ Female___ Date of Birth: _____ Age: _____
*Marital Status: Married ____ Single ____ Divorced ____ Widowed_____
Number of children _____
*Patient social security number: _____
Address: _____ City: _____
State: _____ Zip: _____Phone (Home): _____
Phone (Work): _____ Phone (cell) _____
E-mail address: _____

If responsible party is different from above: Name_____
Address: _____ City: _____
State: _____ Zip: _____Phone : _____
DOB: _____ SS#_____
Insurance info: _____
As the responsible party you will be liable for payment as stated below.

Patient Occupation: _____Employer:_____
Spouse Name: _____Spouse's Employer: _____
Spouse SS#:_____
Name of emergency contact _____Phone #_____
Have you seen a chiropractor before? Yes ___ No___
Chiropractor's name: _____
Who is your primary care physician? _____
How did you hear about our office? _____

Date of accident or beginning of symptoms: _____
Reason for your visit today? _____
Have you had this condition before ? Yes ___No___ When_____
When did it start? _____
What makes it worse_____ What makes it better_____
Does it interfere with Work___ Sleep___ Recreation___ Daily routine___ Other_____

Office use only
O_____
P_____
Q_____
R_____
S_____
T_____

- **Habits:**

- € Smoking: Packs per day _____
- € Alcohol: Drinks per day / week _____
- € Coffee/Tea: Cups per day _____
- € Vitamins/herbs (list all being taken):_____

_____

❖ **Exercise:** ___None; ___Moderate; ___Daily

❖ Have you had any of the following? (Please check or place an "x" in the box)

€ Appendicitis	€ Heart Disease
€ Pneumonia	€ Polio
€ Diabetes	€ Rheumatic Fever
€ Anemia	€ Arthritis
€ Epilepsy	€ Tuberculosis
€ Hypertension	€ AIDS
€ Cancer	€ Alcoholism

❖Have you had any of the following **surgeries**? If yes, please list date.

€ Tonsillectomy_____	€ Gall bladder_____
€ Hernia_____	€ Tubes in ears_____
€ Stomach_____	€ Cataract_____
€ Sinus_____	€ Appendectomy_____
€ Vision correction_____	€ Thyroid_____
€ Female organs_____	€ Breast Surgery_____
€ TMJ_____	€ Hemorrhoids_____
€ Mastectomy_____	€ Neck_____
€ Back_____	€ Prostate_____
€ Heart_____	€ Joints_____

List ALL other surgeries please:_____

❖ List any **broken bones or dislocations**:

_____

_____

Have you ever had a spinal tap or spinal injection? Yes __ No___
Have you even been knocked unconscious? Yes __ No___
Have you ever had a lapse in memory? Yes __ No___
Have you ever had an MRI or CAT scan of your spine? Yes __ No___ **When?** _____

❖ Do you suffer from any condition other than that for which you are consulting us?

_____

❖ Are you presently taking any prescription medication? __ Yes __ No
If yes, please list:

_____

_____

_____

❖ **WOMEN ONLY**
IS THERE ANY CHANCE YOU MAY BE PREGNANT? Yes____ No____

€ cramps	€ painful menstruation	€ hot flashes
€ irregular cycle	€ breast lumps	€ miscarriage

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the doctor's office as a courtesy will bill my insurance for me one time and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for any balance due for services rendered. In our day and time insurance companies are hiring other companies to make demands of paperwork and information under impossible time restraints in order to not be responsible for the bill. You as the patient may not even be aware your insurance company has contracted you out to a 4th party. You as the patient are financially liable for the total amount whether they deny, ignore, or simply do not pay. This agreement supersedes any agreement whether blind or separate with third, fourth or fifth parties that have been contracted by your insurance companies which is not in accordance with the above information on this page and any other party will be considered null and void. You are fully responsible. In case of non-payment or default, I am responsible for all costs of collections including but not limited to court costs and reasonable attorney fees. Additionally in the event of non-payment or default, I will be responsible for any collection agency fees. I understand and agree that all debts not paid by the due date will accrue a TEN dollar ($10.00) monthly charge until balance is paid in full. When using a credit card there is a 5% charge for balances over $400.00. There will be a $35.00 fee for returned checks and credit/debit card charge backs or disputes. There will be a $55 charge for missed appointments. We have a $250.00 maximum balance policy, after your balance reaches $250.00 we have the right to not schedule you until the balance is paid down.

Office Policy: Patient must provide Drivers license, Date of birth, social security number, and insurance card if applicable.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITY TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all the health information maintained, created and/or received by us before the date changes were made. A copy of our Privacy Notice will be available in our office upon request..

WE will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to your primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26,2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services , payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing. Please contact our office for an explanation of our fee structure.

Right to Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26,2013, the Omnibus Rule restricts providers refusal of an individual' request not to disclose PHI.

1. **Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14,2003. Non-routine Disclosures or Requests of Protected Health Information:
   The following are examples of disclosures or requests of PHI that Island Hospital may encounter on a non-routine basis: Subpoenas and/or court orders Investigations by law enforcement Abuse, neglect, or domestic violence investigations Workers' compensation Regulatory or professional licensure reviews. See other types of disclosures in the Notice of Privacy Practices and those in RCW 70.02.050 (1) (b-k)

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel whom have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March26,2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Appointment Reminders: We may use your health records to remind you of your recommended services, treatment or scheduled appointments.

Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

By signing below I acknowledge that I have read and agree to the HIPAA act of 1996.

Patient Signature_____ Date_____

Witness _____ Date_____

How to contact us:

Stephenson Chiropractic & Wellness Center, PC
807 Rhodes Street
Hartselle, Alabama 35640
256-773-1113

STEPHENSON CHIROPRACTIC
Dr. Jason D. Stephenson & Dr. Kimberly Stephenson
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Liability Agreement

Stephenson Chiropractic & Wellness Center, PC has advised me that any examination and/or therapies I receive today may not be considered medically necessary or is a non-covered service. Although Insurance may reduce or deny reimbursement for the procedure(s), I have advised the doctor to proceed with the service(s) and I will assume full responsibility for payment on all procedures. Your insurance agreement is between you and your insurance provider. As a courtesy we will file your insurance for you. We do not file GAP Insurance. You will submit that with your EOB and our bill. This office will resubmit a claim ONE time, after that you are responsible for the entire bill. There is a 3.50 charge for rebilling insurance per claim if you choose to re-bill. There is a 10$ per month fee for non-payment **In the case of MEDICARE**, We cannot predict what Medicare will or will not do - you need to be prepared to pay in case Medicare doesn't. You must meet your deductible at the beginning of each calendar year. **In the case of children**: **Whoever brings the child to their appointment is responsible for payment (Divorce, adoption, foster, etc.)**
In the case of non-payment we will not schedule you until the balance is paid in full. **ALL NUTRITION SALES ARE FINAL!**

Office Policy: Patient must provide Drivers license, Date of birth, social security number, and insurance card (if applicable).

Date:_____Signature:_____

Trust Us To Get You Back In Action

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PATIENT NAME: _____ To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear. The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Analysis / Examination / Treatment As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy palpation vital signs range of motion testing orthopedic testing basic neurological testing muscle strength testing postural analysis testing ultrasound hot/cold therapy EMS radiographic studies The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have

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discussed it with DR. Jason Stephenson and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's name (printed):_____Date:_____

Signature: _____Date:_____

Parent or guardian signature (if a minor):_____Date:_____

PAIN & HEALTH PROBLEMS SURVEY

Name: _____ Date of Birth: _____ / _____ / _____

Email Address: _____ Best Day & Time to Be Reached: _____

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ # Hrs of Work Per Week: _____

CHECK OFF WHICH OF THE FOLLOWING OCCURED AT LEAST ONCE IN THE PAST 30 DAYS:

Pain		Decreased Motion		Swelling		Other Problems
____ Knee	R L	____ Knee	R L	____ Knee	R L	____ Overweight
____ Shoulder	R L	____ Shoulder	R L	____ Shoulder	R L	____ Diabetes
____ Hip	R L	____ Hip	R L	____ Hip	R L	____ Digestive Problems
____ Ankle	R L	____ Ankle	R L	____ Ankle	R L	____ Dizziness
____ Elbow	R L	____ Elbow	R L	____ Elbow	R L	____ Fatigue
____ Back		____ Back		____ Back		____ Balance Problems
____ Neck		____ Neck		____ Neck		____ Neuropathy
____ Wrist	R L	____ Wrist	R L	____ Wrist	R L	____ Sleep Problems
____ Hand	R L	____ Hand	R L	____ Hand	R L	_____ Other

Which health problem bothers you the most? _____

On a scale of 1-10, at it's worst, how bad does it get? (1=low, 10=high) _____

How often does it bother you? _____

How long have you had the problem? _____

What could you do before this problem you cannot do now? _____

HOW DOES THE PROBLEM AFFECT YOU?

☐ Moodiness/Irritability	☐ Restricted Activity	☐ Interferes with Exercise/Hobbies
☐ Decreased Energy	☐ Burden to My Family	☐ Reduced Enjoyment of Life

☐ I would like to receive a consultation and evaluation to determine a natural solution to my problems.

Best day of the week to receive an evaluation: _____

Best time of the day for me to receive an evaluation: _____

We will call to confirm your appointment.