BINNS FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT DATA

Date: __________________ Name:____

Preferred Name:____________________________ Date of Birth: ___________________ Gender: ☐ M ☐ F ☐ X

Marital Status:_____________________________ SSN: ____________________________________

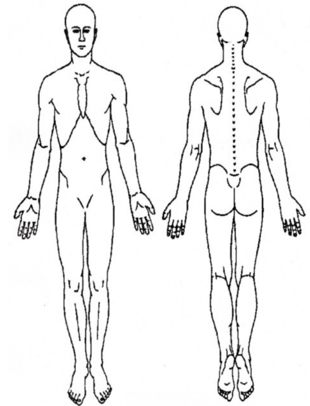
Address:_____________________________________ City:__________________________ State: ____ Zip:______

Phone: Cell______________________ Home__________________ Work____________________ Text: ☐Yes ☐No

Preferred Phone: ☐ Cell ☐ Home ☐ Work Email____

MARK AN X ON THE PICTURE WHERE YOU HAVE SYMPTOMS

Describe your current problem and how it began:



☐ Headache ☐ Neck Pain ☐ Middle Back Pain ☐ Low Back Pain

☐ Other: ____

Is this: ☐ Work Related ☐ Auto Accident ☐ Injury ☐ Other____________________

Date Problem Began: __________________________

How you feel today: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

How often are your symptoms present: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

In the past week, how much has your pain interfered with your daily activities?

(no interference) 0 1 2 3 4 5 6 7 8 9 10 (unable to carry on any activities)

Have you had Spinal X-Rays, MRI, CT SCAN for your area (s) of complaint? ☐ No ☐ Yes

Date taken:________________ What areas were taken? ____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)____________________________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)__________________________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problem (Explain)____________________
____

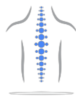
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant (# Weeks)______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Morning Pain/Stiffness
☐ Pain Unreleaved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____________________________________
____
☐ Tobacco Use - Type______________________________
Frequency ___________________________ / Day
☐ Medications____________________________________

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problem/Stroke ☐ Rheumatoid Arthritis

I certify, to the best of my knowledge that the above information is complete and accurate. If my insurance does not cover these services, I understand that I am liable for all charges for services rendered. I agree to notify Dr. Binns immediately whenever I have changes in my health condition or insurance coverage. I understand that Dr. Binns may need to contact my Primary Care Physician if my condition needs to be co-managed. Therefore, I authorize Dr. Binns to contact my Primary Care Physician, if necessary.

Patient Signature______________________________________ Date______________________



BINNS FAMILY
CHIROPRACTIC

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the polices have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protective Heath Information. (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. **www.hhs.gov**

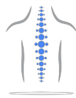
We have adopted the following polices:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers, as is necessary and appropriate for your care. Patients files may be stored in open file racks and not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal coarse of providing care means that such records may be left, at leased temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and /or as required by you. We may send you other communications informing you of changes to office policy and new technology that you might find available or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertizing of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and request change in certain policies to conform to your request.

I acknowledge that I have received and have been informed of the above information.

Print Name____

Patient's Signature ______________________________________ Date ____________________



BINNS FAMILY CHIROPRACTIC

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic X-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctor of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and /or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as it with Healthcare treatment, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvements, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and /or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

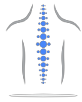
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Doctor of Chiropractic Name: Aaron G. Binns, D.C.

Print Name ____

Patient’s Signature ______________________________________ Date: _________________

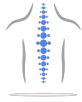


BINNS FAMILY
CHIROPRACTIC

CONSENT TO TREATMENT OF A MINOR

I, being the parent or guardian of ______________________________________,
a minor, the age of _______ , do hereby consent, authorize and request
Binns Family Chiropractic to administer such treatment deemed advisable,
necessary or requested on the above minor.

Parent / Guardian Name: ____
Phone: _______________________
Signature:_____________________________________ Date: ______________



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