Patient Records of Disclosure

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home telephone
  PHONE #:____________________
- ❑ OK to leave message with information
- ❑ Leave message with call back number only

- ❑ Work Telephone
  WORK #:____________________
- ❑ OK to leave message with information
- ❑ Leave message with call back number only

- ❑ Written Communication
- ❑ OK to mail to my home ADDRESS :____________________
- ❑ OK to mail to my work ADDRESS :____________________
- ❑ OK to fax to this number FAX #:____________________

____________________ Patient Signature ____________________ Date

____________________ Print Name ____________________ Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax #	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this if the disclosure is authorized (2) Type Key: T=Treatment records: P=Payment Information: O=Healthcare Operations
(3) Enter how the disclosure was made: F=Fax: P=Phone: E=Email: M=Mail: O=Other

Patient signature:____________________ Date:____________

VARDY HPC - CONFIDENTIAL HISTORY FORM

Name (Mr. / Mrs. / Miss / Ms.):______________________________
First Middle Last Called Name

Physical Address:______________________________
Street City State Zip County

Mailing Address *(If Different)*:______________________________
Street City State Zip

Home Phone: (____) ____________ Work Phone: (____) ____________ Cell Phone: (____) ____________

E-Mail *(Please Print)*:______________________________ ☐ Work ☐ Personal

Race: *(Check only 1)* ☐ White / Hispanic ☐ Black/African American ☐ Asian ☐ Native Hawaiia
☐ American Indian/Alaska Native ☐ Other Pacific Islander ☐ Other__________ ☐ Decline to State

Ethnicity: *(Check only 1)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State

Preferred Language: ______________________________ ☐ Decline to Stat

☐ Single ☐ Married ☐ Other Spouses Name:____________________ Spouse DOB:____/____/____

Date of Birth:____/____/____ Age:________ SSN:____________ DL:____________ State:________

Who (or what source) referred you? ☐ Phone Book ☐ Internet ☐ Newspaper / Coffee News
☐ Community Event ☐ Household Mailing ☐ Other__________
☐ Friend or Family Member (Name:______________________________

Occupation:____________________ Employer:____________________ Work Phone: (____) ____________

Occupation Address:______________________________
Street City State Zip

Nearest Relative Not Living With You:____________________ Relative Relationship:____________

Relative Address:______________________________ (____) ____ - ____
Street City State Zip Phone

Previous Chiropractic Care: [ ] YES [ ] NO Doctor's Name:____________________

Name of Health Insurance Company:______________________________

Insurance Holder's Name:____________________ Date of Birth:____/____/____. SSN:____________

Insured's Employer:____________________ Your Relationship: ☐ Self ☐ Spouse ☐ Mother ☐ Fathe

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IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED:

I do hereby authorize Vardy HPC to furnish my Insurance Co. with full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury if requested by them. I hereby authorize and direct payment directly to said doctor such sums as may be due owing him for chiropractic service rendered me. I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL MEDICAL BILLS SUBMITTED BY HIM FOR SERVICE RENDERED ME. This agreement is made solely for said doctors' additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting the doctor's interest, he will not await payment but may declare the entire balance due and payable: these assigned proceeds shall not exceed amounts due and payable to doctor for services rendered.

Patient Signature:______________________________ Date:____________

If Minor, Parent/Guardian Signature of Consent:______________________________ Date:____________

Office Witness: Date: ACCT #:

For Office Use Only
Account Number: ____________
Patient Height: ____________
Patient Weight: ____________
Patient BMI: ____________
Patient BP: ______ / ______

Vardy HPC

EHR Health Information

General Information

Smoking Status: *(Check only 1)* ☐ Current Every Day Smoker ☐ Smoking: Start Date: ________ End Date: ________
☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker

If Yes, What is your level of interest in quitting smoking? ☐ No Interest ☐ Slight Interest ☐ Very Interested

In an effort to quit smoking, I am currently taking: ________________________________

Do you currently take Medications? ☐ Yes ☐ No
If Yes, please indicate the following:

Medication: ____________
Route: ☐ *Oral* ☐ *Intravenous*
Other: ____________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Medication: ____________
Route: ☐ *Oral* ☐ *Intravenous*
Other: ____________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Medication: ____________
Route: ☐ *Oral* ☐ *Intravenous*
Other: ____________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Medication: ____________
Route: ☐ *Oral* ☐ *Intravenous*
Other: ____________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Do you have any Allergies? *(General or Medication)* ☐ Yes ☐ No
If Yes, please indicate the following:

Allergy: ____________
Reaction: ____________
Start Date: ____________
End Date: ____________

Allergy: ____________
Reaction: ____________
Start Date: ____________
End Date: ____________

Check for Symptoms You Are Having

☐ Headaches
☐ Neck Pain
☐ Stiff Neck
☐ Mid Back Pain
☐ Low Back Pain
☐ Chest Pain
☐ Left / Right: Shoulder Pain
☐ Left / Right: Arm Pain
☐ Left / Right: Hand / Wrist / Finger Pain
☐ Left / Right: Hip Pain
☐ Left / Right: Leg Pain
☐ Left / Right: Knee Pain
☐ Left / Right: Foot Pain
☐ Other: ____________
☐ Nausea
☐ Irritability
☐ Fatigue
☐ Dizziness

Have you seen a doctor for these symptoms: ☐ Yes ☐ No
Is this complaint due to a work related or auto accident: ☐ Yes ☐ No
Any time lost from work due to this illness or accident: ☐ Yes ☐ No From: ____________ To: ____________

Has any Doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No
Has any Doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II
Have you had an X-Ray / CT Scan / MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

Patient Signature: ________________________________ Date: ____________

If Minor, Parent/Guardian Signature of Consent: ________________________ Date: ____________

Office Witness: ____________ Date: ____________ ACCT #: ____________

Health history

Medical Conditions: (Check all that apply to you)

□Arthritis □ Cancer □Diabetes □ Heart Disease
□ Hypertension □ Stroke □ Skin Disorder □ Medical/Psychiatric Illness
□ Good Health prior to accident □ Non- Contributory □ Other ___________________________

Surgeries/Injuries/Hospitalizations: (Check all that apply to you)

□Appendectomy □Cardiovascular procedure □Cervical spine □Thoracic spine
□ Lumbar spine □Hysterectomy □Joint replacement □Prostate
□Gall Bladder □Brain □Shoulder □Knee
□Carpal Tunnel □Gastro-Intestinal □Uro-Genital □Hernia
□Other ________________________________ Hospitalizations:________________________

Allergies: (Check all that apply to you)

□Foods □Dust □Pollen □Medications □Other_______________

Social History: (Check all that apply to you)

Marrital status: □Single □Married □Divorced □Widow □Other
Caffeine use: □ 1 cup/day □ > 1 cup/day □never
Drink Alcohol: □ occasional □often □never
Tobacco use: □ <1 pack/day □ >1 pack/day □ never
Drug Use (Illegal) □ occasional □often □never
Exercise: □ occasional □often □never
Other: ____

Family History: (Check all that apply) List if Parent or Sibling

□Arthritis:__________ □Cancer_________ □Diabetes __________ □Heart Disease__________
□High blood pressure__________ □Thyroid problems__________ □ Depression __________
□High cholesterol__________ □ Other __________

Nutrition Habits: (check all that apply)

□ Meals a day _____ □ Balanced home cooked meals □ Fast food □Vegetarian □ Vegan

Occupational Activities: (Check one that best describes your job description)

□ Administration □ Business Owner □Clerical/Secretary □Computer U
□Heavy Equipment operator □ Daycare/Childcare □Construction □ Health Care
□ Food Service Industry □ Medium Manual Labor □ Manufacturing □ Home Servi
□Heavy Manual Labor □Light Manual Labor □Executive/Legal □ Housekeeper
□ Other ________________________________

Patient signature:____ Date:________

Office Witness:___________________ Date:_______________ ACCT #:____

WENDELL OFFICE: KNIGHTDALE OFFICE:
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Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	**Eyes/Head**	Past	Present	No	**ENT/Upper Respiratory**	Past	Present	No
Pace Maker				Headache				Hearing Loss			
Poor Circulation				Heavy Headed				Ear Pain			
Chest Pain				Light Headed				Ear Infection			
Palpitations				Dizziness				Ear Discharge			
Difficulty Breathing				Visual Changes				Ear ringing			
Asthma				Eye pain				Sinus Pain			
Cough				Eye discharge				Sinus Congestion			
Swelling of legs				Corrective lenses				Nose Discharge			
				Glaucoma				Nose Bleed			
Vascular	Past	Present	No	Double Vision				Snoring			
Swelling				Blurred Vision				Allergy			
Numbness								Difficulty Swallowing			
Coldness				**Breast**	Past	Present	No				
Cramps				Pain				**Gastrointestinal**	Past	Present	No
Varicose Veins				Lumps				Gall Bladder problems			
				Discharge				Bowel Problems			
Urinary Tract	Past	Present	No					Pain			
Kidney Pain				**Female Only**				Gas			
Frequent Urination				**Pregnant**	**Yes**	**No**		Bloating			
Painful Urination				Other list below	Past	Present	No	Constipation			
Urination Urgency								Diarrhea			
Incontinence								Ulcers			
Bladder Infection											
Kidney Infection				**Male Issues**	Past	Present	No	**Musculoskeletal**	Past	Present	No
Kidney Stones				List any below				Joint Pain			
								Limited Motion			
Skin	Past	Present	No					Stiffness			
Clammy				**Mental**	Past	Present	No	Sore Muscles			
Dermatitis				Nervousness							
Dryness				Tension				**Neurological**	Past	Present	No
Eczema				Confusion				Seizures			
Fungal Infections				Mood Swings				Paralysis			
Itchiness				Depression				Numbness			
Lump				Memory loss				Other			
Pasty											
Psoriasis				**Endocrine**	Past	Present	No	**Allergy/Immune**	Past	Present	No
Rash				Thirst				Food Allegies			
				Hunger				Hay Fever			
Hematologic	Past	Present	No	Urination				Pet Allergy			
Anemia				Fatigue				Prone to Infection			
Blood Clots				Ankle Swelling							
Sore lymph node				Weakness				**Other:**			
B12 Deficiency				Weight Change							

Please list all current medications being taken ____

Patient signature:____ Date:___________

Office Witness:________________ Date:_____________ ACCT #:__________

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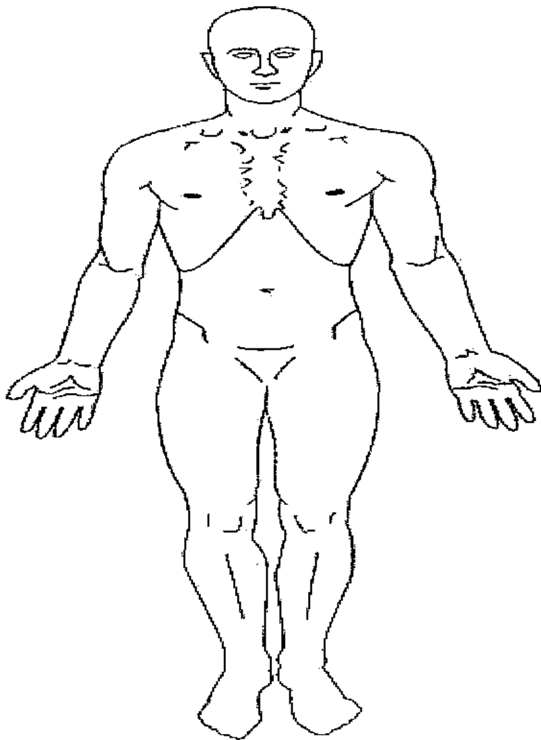
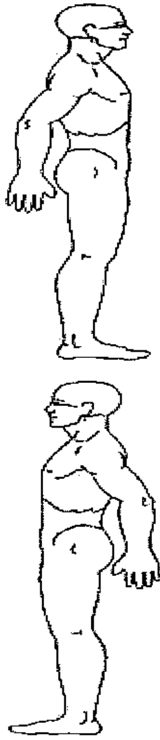
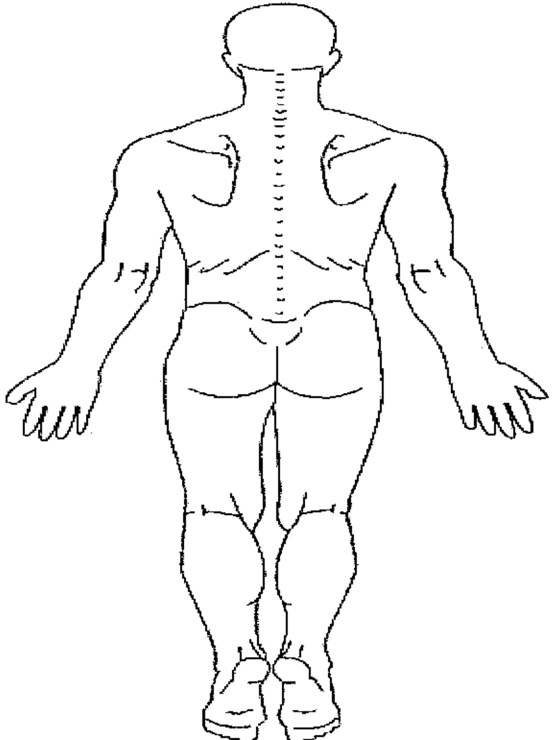
By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**







Describe your symptoms in order of severity, with worse symptom being #1: ____________________

____

____

____

When did your symptoms begin? **Month**____________ **Day**__________ **Year** ______________

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? ____

____

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

Sharp Dull ache Numb Shooting

Patient signature:____ Date:____________

Office Witness:_________________ Date:_____________ ACCT #:___________

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PATIENT CONSENT FORM

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here ______________________ and /or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr.___________________ and /or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited, to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all the risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Vardy Chiropractic and Wellness Clinics to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period __________.

Patient's Signature: ______________________________ Date:_______ Front Desk________ Date:______
Patient Name: ____________________________________ DOB: __________ ACCT: __________

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METHOD OF PAYMENT CHOICE

PLEASE CHECK AND SIGN THE METHOD YOU PREFER TO USE TO PAY FOR SERVICES RENDERED FROM
VARDY HUMAN PERFORMANCE CENTER.

( ) NON-INSURANCE

( ) I wish all my Chiropractic Records, Including my Personal History, Findings from any Examination, X-Rays or Laboratory Procedures to be held in strict secret confidence and not be given to anyone without written consent.

( ) HEALTH INSURANCE ( ) Medical PAY / LIABILITY INS. / ATTORN

( ) I hereby authorize Vardy Human Performance center to release information to my Attorney, Insurance Company or Related person request such information.

Signature ______________________ Date ______________

- Non-payment on an account for more than 30 days will result in a 1.5% late fee per month.

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces you pocket expense and allows you to place your family under care

1) All Missed Appointments without a 24 hour notice are subject to a $25 charge.

2) ***If You Do Not Have Insurance:*** All payments are expected at the time of service or by an authorized payment pl personal balance may not exceed $200 at any time or care may be terminated. Our payment plans make care an affordabl your family budget.

3) ***If You Have Insurance:*** All deductibles and co-payments are expected at the time of service or by an authorized paym Your co-insurance balance may not exceed $200 or care may be terminated. Our payment plans make care an affordabl your family budget.

   You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your i coverage. We gladly accept assignment for secondary insurance.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the m allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment i any outstanding balance and authorize us to use your credit card to collect full payment.

   If you discontinue care for any reason, all balances will become immediately due and payable in full by you and an insurance balances that result in a patient balance, will then be your responsibility also.

Patient's Printed Name: ______________________________
Patient's Signature: ______________________________ Date: __________ Front Desk____________ Date:____

For your convenience you may retain your credit card number on file with us.
Card #:____ Expiration Date: ________
Name as appears on card: ______________________________