Becker Spine & Sports Institute
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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature Date

Health Questionnaire

Patient Name:	Date:

MUSCULO SKELETAL SYSTEM
- Low Back Pain
- Mid Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Spasms
- Broken Bones
- Shoulder Pain

GENITO-URINARY SYSTEM
- Bladder Trouble
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urine

FEMALE
- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain
- Lump in the Breast

PREGNANT:
Yes No

GASTRO-INTESTONAL SYSTEM
- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Excessive Thirst
- Nausea
- Vomiting Blood
- Abdominal Pain
- Diarrhea
- Constipation
- Black Stool
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble

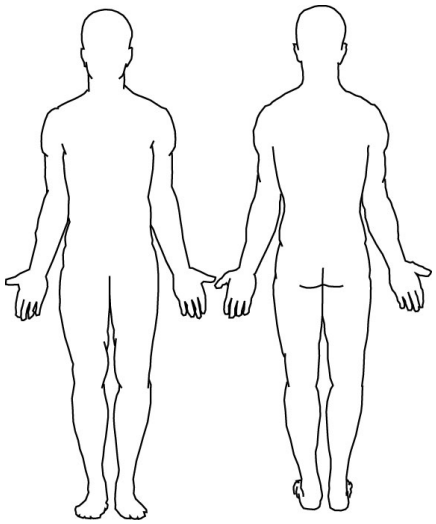
NERVOUS SYSTEM
- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS
- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- Other: _____

CARDIO-VASCULAR RESPIRATORY
- Chest Pain
- Pain Over Heart
- Difficultly Breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problems
- Heart Problems
- Lung Problems
- Varicose Veins

EYE, EAR, NOSE & THROAT
- Eye Strain
- Eye Inflammation
- Vision Problems
- Ear Pain
- Ear Noises
- Ear Discharge
- Hearing Loss
- Nose Pain
- Nose Bleeding
- Nose Discharge
- Difficultly Breathing (Nose)
- Sore Gums
- Dental Problems
- Sore Mouth
- Sore Throat
- Hoarseness
- Difficult Speech
- Sinus
- Allergy
- Jaw Pain

SYMPTOM LOCALIZATION



P - Pain
N - Numb
S - Spasm
T - Tender
H - Hypoethesia

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature: _____

* * * * * * * * * * OFFICE USE ONLY * * * * * * * * * *

_____

_____

_____

_____

Patient Accepted? Yes No

Doctor's Signature: _____

Becker Spine & Sports Institute

Patient Personal / Confidential Data

Name:			Date:
Email Address:			
Street Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
DOB:	Age:		SS:
Employer:		Telephone:	
Street Address:			
City:		State:	Zip:
Name of Spouse:		Telephone:	
Emergency Contact:		Telephone:	

Patient's Insurance

Insurance Name:
ID & Group #:
Telephone:

Spouse's Insurance

Insurance Name:
ID & Group #:
Telephone:

Chief Complaint Information

Purpose of this appointment & list your complaint:		
Date of Illness:	Time:	Location:
How did the accident occur? Auto At Work Other:		
Please describe the circumstances & what makes the condition(s) better or worse:		
Other Doctor seen for this condition:	Telephone:	
Have you been treated by a Doctor for any health condition in the last year: Yes No		
If yes, please describe:		

Insurance Information

I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand this Chiropractic Office will prepare any necessary reports & forms to assist me in making collection from the insurance company & that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered to me are charges directly to ma & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Physician Signature:	Patient Signature:

Consent of Professional Services & Release of Information

I hereby authorize & release the doctor & whom ever he may designate as his assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; and further authorize him to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient Signature:	Parent/Guardian's Signature: