Welcome

Date:________________

Name:_____________________________________ Birth Date:______________ Age: ______
first *middle* *last*

Address:____
city *state* *zip*

Telephone (Home):_______________ (Mobil):_______________ E-mail:________________________

❑ Single ❑ Married ❑ Significant Other ❑ Widowed ❑ Separated ❑ Divorced

Occupation/employer: ____

Work Environment (prolong sitting, computer work, stress, etc.)______________________________

How did you hear about us? ____

Health Profile

Have you received Chiropractic care before? Yes No If Yes, last adjustment?____________________

What are your health challenges that brings you to our office?________________________________

When did you first notice this problem?__________________ Have you experienced this problem before? Yes No

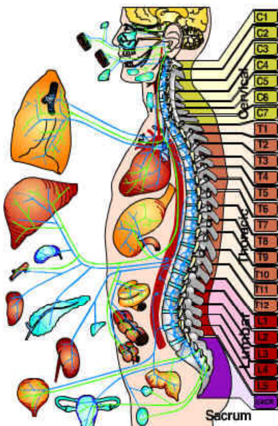
What solutions have you tried to resolve this problem? ____________________________________

Accidents/Falls/Surgeries (since birth): ____

Current Medications:_______________ Vitamins/Supplements:_______________ Women: are you pregnant?_____

Lifestyle Habits (please check): ❑ Eating Healthy | ❑ Exercise Regularly | ❑ Meditate/Yoga |

❑ Natural Health Solutions | Other: _______________



- ❑ Headaches
- ❑ Neck Pain
- ❑ Numb/Tingling arms/hands
- ❑ Carpal Tunnel Syndrome
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Pain between Shoulders
- ❑ Shoulder Pain
- ❑ Asthma
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Leg Pain / Sciatica
- ❑ Digestive Problems
- ❑ Fatigue / Lack of Energy
- ❑ Menstrual Cycles/ Female disorders
- ❑ Mood Swings / Depression
- ❑ Frequent Colds / Flu
- ❑ Insomnia / Difficulty Sleeping
- ❑ No problems - Wellness Care
- ❑ Other_______________

The nervous system that exits from the spine controls all body function.

On the diagram to the right, please use the abbreviations below and mark on diagram where you feel that described sensation(s) including radiating pain.

D = Dull Pain **N** = Numbness **ST** = Stiffness
A = Ache **T** = Tingling **B** = Burning/Throbbing
S = Sharp Pain **W** = Weakness **G** = Stabbing/Gripping

Indicate area (i.e. neck, low back) 0 is no discomfort/pain and 10 is worst possible
Area:__________ Rate: 1 2 3 4 5 6 7 8 9 10 Circle: Constant or Intermittent
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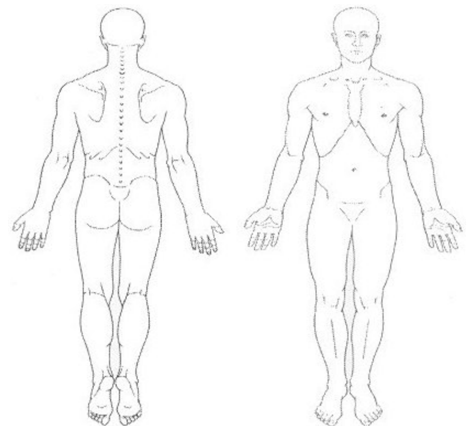

Fimreite Chiropractic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care as a patient at Fimreite Chiropractic, we may need to use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (if they are, or may be, responsible for the payment of your services).
- Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with another member of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, insurance forms or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and to protect the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected be the federal privacy rules.

- Open adjusting rooms: we keep an open environment in the office to create a sense of warmth, family, healing and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.

- To Family and close friends involved in your care: Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office recommends that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness.

In addition, we may disclose your Personal Health Information (PHI) to a family or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- Requesting Restrictions: You have the right to request a restriction in how we use of disclose you PHI. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.

- Right to inspect and copy: You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our Practice. We will usually respond to your request within sixty (60) days. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

If we charge a fee, we will let you know the fee in writing, prior to making the copies, so that you can withdraw or modify your request before incurring a charge. In addition, we may charge to make copies of your record to send to another health care provider; if so, we will notify you in writing prior to making the copies.

We may deny your request to inspect and copy your PHI in certain circumstances. If you are denied access to your PHI, you may request that the denial be reviewed in certain circumstances. Another licensed health care professional chosen by the Practice will review your request and our denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

If you have a complaint regarding our privacy notice and/or our privacy practices, or would like further information about our privacy policies and practices please contact:

Gordon K. Fimreite, D.C.
4727 Willow Springs Road
La Grange, IL 60525
(708) 352-3325

This notice is effective as of July 22, 2010. This notice, and any alterations or amendments made thereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____

Name (please print) Signature Date

If you are a minor or if another party is representing you:

____

Personal Representative Name (please print) Personal Representative Signature Date

Description of the authority to act on behalf of the patient: ____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

____

Name (please printed) Signature Date

If you are a minor or if another party is representing you:

____

Personal Representative Name (please print) Personal Representative Signature Date

Description of the authority to act on behalf of the patient:

____