

# MILLER CHIROPRACTIC CENTER

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Protection* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes and,
- The right to request restriction as to how my health information maybe used or disclosed to carry out treatment, payment, or health care options.

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
Relationship to PATIENT/SELF

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

## HIPAA Consent Form

The health insurance Portability and Accountability Act of 1996(HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health information regarding treatment, payment, or health care operations, in order to provide health care that is your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your health information, but this must be done in writing. Under this law, we have the right to refuse to treat you if should choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager. You have the right to review our privacy notice, to request restrictions and revoke consent in writing

\_\_\_\_\_  
Patients or Guardian **Signature**

\_\_\_\_\_  
Date

Patient Information

**PLEASE FILL OUT THE FOLLOWING FORMS AS COMPLETE AS POSSIBLE. ALSO, PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE OR VALID PICTURE ID AND INSURANCE CARD TO FRONT DESK. THANK YOU**

Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_  
 City/STATE/ZIP: \_\_\_\_\_ Phone #: Home cell \_\_\_\_\_

Employment (job): \_\_\_\_\_

**Email (please Print):** \_\_\_\_\_

**Marital status:** Divorced Married Separated Single Widow **Patient Type:** Self Insurance PIP Auto Accident

**Patient's state current problem and start date?** \_\_\_\_\_

\_\_\_\_\_

**Have you lost any time from work?** Yes No **Do you need a note for work?** Yes No

Have you seen any other doctors for this condition? Yes No

Who? \_\_\_\_\_ Phone: \_\_\_\_\_

Prior Injuries \_\_\_\_\_

For Females: Are you pregnant? Yes or No Do you take birth control pills? \_\_\_\_\_

Do you have a **Pacemaker** or **defibrillator**? \_\_\_\_\_

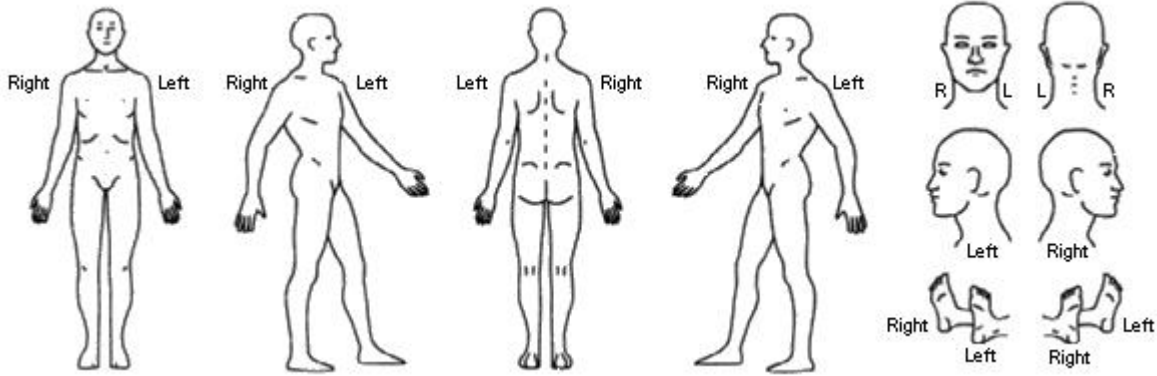
List any conditions, tests or exams in **last 10 years** we should know about. (Surgeries, falls, head injuries, broken bones, dislocations, etc.) \_\_\_\_\_

\_\_\_\_\_

Choose those that apply to you

Abdominal	Depression	Kidney Disease	Sciatica
Alcoholism	Diabetes	Liver disease	Short of breath
Allergy	Dizziness	Mental disease	Sinus trouble
Anemia	Gall bladder	Migraines	Sleeplessness
Arthritis	Gout	Multiple sclerosis	Stress
Asthma	Gynecological	Nausea	Stroke
Cancer	Headaches	Neck pain	Thyroid problems
Cataracts	Hearing Trouble	Osteoporosis	Tumors, Growths
Chest pain	Heart disease	Parkinson's disease	Ulcers
Cold hands/feet	Hemorrhoids	Polio	Varicose veins
Colds/infections	Hardening of arteries	Poor appetite	Vision problems
Colon trouble	Hepatitis	Prostate	Poor appetite
Constipation	Herniated Disc	Rheumatoid	Weight Gain/Loss
Concussion	High Cholesterol	Scarlet fever	Whooping cough

# Pain Location & Description



\*Place a X on each of complaint on the pictures above:

Please **describe** what you think might have caused your complaints:

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\*Complaint 1: \_\_\_\_\_ Radiating? Yes or No \_\_\_\_\_  
 (pain location) (to what area)

**Describe the pain:** (please circle one or more that apply): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

**How often is this pain occurring?** (please circle one): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

**Current Severity:** (please circle one or more that apply): mild, mild-moderate, moderate, moderate to sever, sever

\*Complaint 2: \_\_\_\_\_ Radiating? Yes or No \_\_\_\_\_  
 (pain location) (to what area)

**Describe the pain:** (please circle one or more that apply): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

**How often is this pain occurring?** (please circle one): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

**Current Severity:** (please circle one or more that apply): mild, mild-moderate, moderate, moderate to sever, sever

\*Complaint 3: \_\_\_\_\_ Radiating? Yes or No \_\_\_\_\_  
 (pain location) (to what area)

**Describe the pain:** (please circle one or more that apply): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

**How often is this pain occurring?** (please circle one): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

**Current Severity:** (please circle one or more that apply): mild, mild-moderate, moderate, moderate to sever, sever

\*Complaint 4: \_\_\_\_\_ Radiating? Yes or No \_\_\_\_\_  
 (pain location) (to what area)

**Describe the pain:** (please circle one or more that apply): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

**How often is this pain occurring?** (please circle one): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

**Current Severity:** (please circle one or more that apply): mild, mild-moderate, moderate, moderate to sever, sever

I UNDERSTAND and AGREE to authorize Dr. Miller and his employees to administer any examination procedures and treatments as they deem necessary.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

## Vehicle Accident Information

**Patient Name:** \_\_\_\_\_ **Date Of Accident:** \_\_\_\_\_

**Height** \_\_\_\_\_

**Weight** \_\_\_\_\_

Did you go to **the hospital / ER or Doctor?** Yes or No

**Transportation:** (circle one) ambulance or private vehicle

**Name of Hospital:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Medication prescribed:** \_\_\_\_\_

**Did you receive a bone scan, CT Scan, MRI or X-ray ?** (Circle any tests performed)

**Was there a police report filed:** yes or no (circle one)

**Patients Vehicle Type:** \_\_\_\_\_

**Were you the:** (circle one) Driver, Front Passenger, Back seat behind driver, Back seat behind front passenger

**Were you wearing a seat belt?** (circle one that applies): none, lap belt only, seat belt with shoulder harness

**Did the air bags deploy?** yes or no (circle one)

**Where was the vehicle impacted?** (circle one that applies): front bumper, left front fender, left rear fender, left side, rear bumper, right front fender, right rear fender, right side

**Other Vehicle Type:** \_\_\_\_\_

Please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_