Elevate Chiropractic

147 W 400 N Orem, UT 84057
Office: 801 221- 9060 Fax: 801 221-9071

Patient Information

Name _____ M F Age _____ Birthday_____

Social Security # _____ Marital Status_____

Address _____City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone _____ Email _____

Spouse/Parent Name _____Phone _____

Employer Name _____ Phone_____

Referring Physician _____Phone _____

Nearest relative not living with you _____Phone _____

Insurance Information

Check if self-pay ☐ Check if insured is same as patient ☐

Primary Insurance _____ Policy # _____

Primary Insurance Holder _____ Birthday _____

Secondary Insurance _____ Policy # _____

Secondary Insurance Holder _____ Birthday _____

Check if the injury was incurred by an accident Auto☐ Work☐ Date of Accident _____

Insurance _____ Claim # _____

Describe accident _____

Assignment of Benefits

I hereby assign my medical benefits for services rendered here to which I am entitled including Medicare, private insurance, and any other plan to Elevate Chiropractic. This assignment will be in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as any original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby agree to pay a delayed payment fee at a rate of 18% annually on any unpaid balance after 30 days from the date of service. I further agree to pay all costs of collection including collection fee, attorney, and court costs.

☐ I have read the HIPAA Notice of Privacy Practices.

Signature _____ Date _____

(Parent or legal guardian sign if patient is a minor)

Present Injury

What is your primary complaint? _____ Date of onset? _____

How did the injury occur? _____Was onset gradual? Yes No

What reduces symptoms? _____

What aggravates symptoms? _____

Was surgery performed for present injury? Yes No If yes, date of surgery? _____

Is any medication being taken for this condition? Yes No If yes, please list _____

_____

Does medication help? Yes No

Has treatment been received for this condition previously? Yes No If yes, When? _____

Whom? _____ Where? _____

Type of treatment? _____

Do you participate in any sports, exercise programs or activities on a regular basis? Yes No

If you are having pain, please rate the intensity on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain. _____

Please Indicate where your symptoms are located:

Numbness = = =

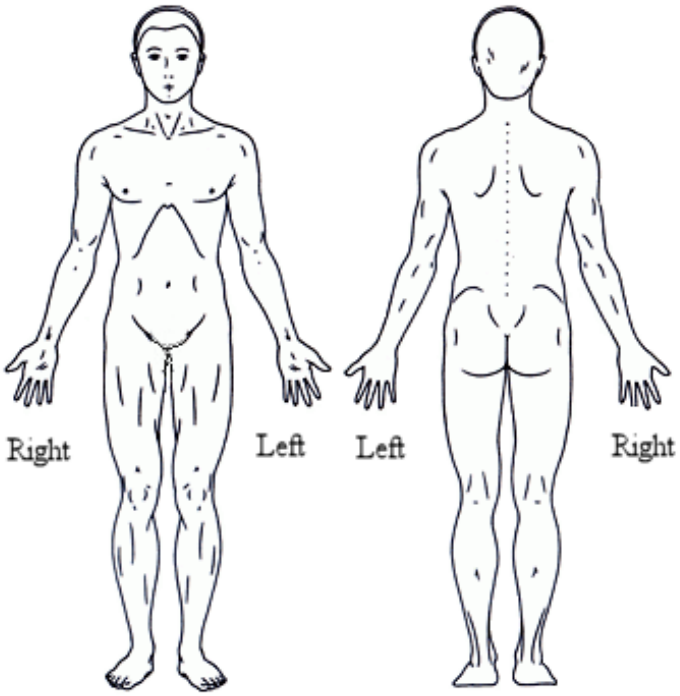
Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^



Medical History

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

If yes on any of the above, please explain _____

_____

Please list all surgeries _____

_____

☐ I affirm that the above information is accurate and true.

Signature _____ Date _____
(Parent or legal guardian sign if patient is a minor)

HIPAA Notice of Privacy Practices

Elevate Chiropractic
147 W. 400 N. Orem, UT 84057
(801) 221-9060

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law it also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of **Protected Health Information.**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to your, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected heath information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Required By Law, Public health issues as required by law, Communicable Diseases: Health Oversight Abuse or neglect; Food and Drug Administration requirements: Legal Proceeding: Law enforcement: Coroners, Funeral directors, and Organ Donation:

Research: Criminal Activity: Military Activity and National Security: Workers' compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when requirements of section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit, to use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the secretary of Health and Human Services if you believe your primary rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.