Office Policy (prior to 1st treatment)

*Credit Card is to be on file
*need photo ID/Lic. + Ins. Card
*new patient paperwork completed

NEW PATIENT INFORMATION

DATE:_______/________/_______CELL PHONE:____

NAME: *(First)*______________________*(MI)*_____*(Last)*____

ADDRESS:____

CITY:__________________________________STATE:_____________ZIP CODE:________________________

BIRTHDATE:_____/_____/_____ **Sex:** Male ☐ Female ☐ **Marital Status: S** ☐ **M** ☐ **D** ☐ **W** ☐

PATIENT INFORMATION:	**SPOUSE INFORMATION:**
Occupation:	Spouse Name:
Work Phone:	Occupation:
Employer:	Work Phone:
City & State:	Employer:
E-Mail Address:	City & State:
Cell Phone:	Date of Birth:

How did you find out about us?

☐ Website ☐ Internet ____________ ☐ Advertisement______________ ☐ BCBS Site ☐ OTHER______________

☐ Referral from a physician _______________________ *(Name)* ☐ Referral from a friend/family______________________ *(Name)*

☐ Have you had Physical Therapy this year? (Circle one) YES NO If yes, where ______________________

☐ Have you been or are you on Home Health Care? (Circle one) YES NO

☐ Is this related to a Workman's Comp Case or Auto Accident Case? (Circle one) YES NO

.

Primary Care Physician: (If other than the referring physician)____

Address:_____________________________ City:________________________State:____Zip Code: ___________

Specialty: ____Telephone: ______________________________

Pharmacy:____Phone:________________________________

Insurance Information: *Please, take picture and text to our office front Photo ID/Lic. + front & back Ins. Card

Primary:	ID#:	Group #:
Tel:		Insured's Name:

In Case of Emergency, Contact:__________________________________Phone:_______________________

Assignment of Benefits/Release of Information:

I authorize payment of insurance benefits directly to Dr. Thomas George S.C. I authorize to execute any documents necessary to secure the payment of benefits and obtain any records from any other source necessary for the course of my treatment. I agree to be financially responsible for all charges incurred during treatment by Olympico Chiropractic Clinic including my insurance deductible co-payment, and services not covered by my insurance carrier or paid in full through any settlement or court case. Any remaining balances I will pay in full per the policies of Olympico Chiropractic Clinic. I agree that missed or canceled appointments without 24 hours notice will be charged to my credit card on file $180.00 or billed to me, or rescheduled appointments without 24 hours notice will be charged to my credit card on file $35.00 or billed me.

Signature:____Date:_________________________________

Patient History

NAME:____**AGE:**____________**DATE:**_________________________

WHAT IS YOUR REASON FOR YOUR VISIT TODAY?____

Primary Care Physician: ______________________________DATE OF LAST PHYSICAL EXAM:__________________

HEALTH STATUS (please circle):

Chills	Poor Appetite	Chest Pain	Itching
Depression	Bloating	High/Low Blood Pressure	Changes In Moles
Dizziness/Fainting	Bowel Changes	Swelling in Ankles	Rash
Fever	Constipation	Varicose Veins	Scars
Sweats	Diarrhea	Blurred/Double Vision	Sore (non-healing)
Forgetfulness	Excessive Hunger/Thirst	Earache/Ringing In Ears	Low Back Pain
Headaches/Migraines	Gas	Sinus Problems	Neck Pain
Sleep Loss	Indigestion	Allergies	Leg/Arm Pain
Weight Loss	Nausea/Vomiting	Nosebleeds	Other:_____________
Nervousness	Difficulty Swallowing	Persistent Cough	________________
Numbness	Rectal Bleeding	Bruise Easily	________________

For Women

Date of Last Menstrual Period:_________________________Last Pap Smear:______________________________

Date of Last Mammogram:____________________________Pregnant Yes / No No. of Children___________

Complications, (if any) with childbirth?____

Have you experienced (please circle):

Abnormal Pap Smear   Abnormal Bleeding   Breast Lump/Pain   Vaginal Discharge

HEALTH HISTORY (please circle):

AIDS	Chicken Pox	Hernia	Polio	Tonsilitis
Alcoholism	Diabetes	High Cholesterol	Prostate Problems	Typhoid Fever
Anemia	Emphysema	Kidney/Liver Disease	Psychiatric Care	Ulcers
Appendicitis	Epilepsy	Measles	Rheumatic Fever	Vaginal Infections
Bronchitis	Gout	Miscarriage	Scarlet Fever	Venereal Disease
Cancer	Heart Disease	Pacemaker	Stroke	Other:_____________
Cataracts	Hepatitis	Pneumonia	Thyroid Problems	________________

Please List *Prescriptions* and *OTC Medications*: (Use back if needed)   Please List *Medical Allergies*:

________________________   __________________________   ______________________________

________________________   __________________________   ______________________________

________________________   __________________________   ______________________________

Family Health History

Relation	Age	Status of Health	Age of Death	Cause of Death
Father				
Mother				
Brother (s)				
Sister (s)				

Family History (please check below if any applies)

Check	Condition	Relationship
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Health Habits
(please mark if using the following)

_____ Caffeine: How much? _____________

_____Tobacco: How much? _____________

_____Drugs: How much? _____________

_____Other:___ _______________________

Surgeries and Hospitalizations

Date	Reason for Hospitalization/Type of Surgery	Outcome/Results

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ _____________/___________/_____________
Patient Signature Date

____ _____________/___________/_____________
Reviewed By Date

Name: ____ Date: ____/______/______

Please state your initial problem and/or reason for visiting today?

____

____

____

Date Condition/Problem began? _________________________________

What is the frequency of your symptoms? ____Constant ____Frequent ____Intermittent ____ Occasional

SCALE of **<u>0 to 10</u>**; 0 representing ***no pain*** and 10 the ***most severe pain***, please circle the appropriate number below.

Please rate your pain today? 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Since your pain started, how would you rate your ***<u>least</u>*** pain level?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Since your pain started, how would you rate your ***<u>worst</u>*** pain level?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If your initial pain is a pain complaint, does it radiate? _____YES _____ No

If yes, where to? ____

Please check if your initial complaint effects your movement by the following:

_____Inflexibility _____Stiffness ____Spasm _____ Cramp

If your initial complaint gives you sensations, please check from the following:

____Crawling	____Tingling	____Deadness	____Prickly
____Pins & Needles	____Stabbing	____Hurting	____Pulsating
____Burning	____Shooting	____Throbbing	____Aching
____Stinging	____Excruciating	____Dull	____Pounding

What aggravates your complaint?

____Flashing Lights	____Sneezing	____Lifting	____Exercising
____Looking Up/Down	____Coughing	____Sitting	____Stooping
____Looking side to side	____Anger	____Standing	____Depression
____Driving	____Stress	____Walking	____Getting out of Bed
____Pushing	____Emotional Upset	____Pulling	____Repetitive Movements
____Carrying	____ Straining at BM	____Climbing Stairs	____Walking up hill
____Getting in/out of Car	____Other____________		

What relieves you initial complaint?

____Resting	____Sleeping	____Cold	____Heat
____Sitting	____Shower	____Advil	____Aspirin
____Tylenol	____Pain Pills	____Treatment	____Mineral Ice

____Other__________________

Patient Name: ____ Date:_______/_______/_______

Please Circle the correct answer for each question:

1. Have you ever had blood clots? Yes No
2. Have you ever had a hernia? Yes No
    a. If yes, How long ago? ________________
3. Do you have Spondylolisthesis? Yes No
4. Have you ever had a compression fracture? Yes No
5. Have you ever had a hip, knee or foot implant (artificial)? Yes No
6. Are you pregnant? Yes No
7. Do you have a pacemaker? Yes No
8. Do you have any metal in your body (Plates or screws)? Yes No
9. Do you have an infection? Yes No
10. Do you have diabetes? Yes No
11. Do you have any stints for your Heart or Arteries? Yes No
12. Do you have a severe heart problem? Yes No
13. Do you have epilepsy? Yes No
14. Do you or have you had cancer? Yes No

NOTICE OF PRIVACY PRACTICES

In compliance with a newly enacted Federal Law, the **Health Insurance Portability and Accountability Act (HIPAA), Olympico Chiropractic Clinic** is informing you of your privacy rights. Please review this notice carefully.

What is HIPAA?
HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). *PHI is confidential information about a patient, including demographic information.*

What are my rights under HIPAA?
Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

You have a ***right to inspect and obtain a copy of your PHI.*** We will respond to your request within 30 days.
In most cases your request will be honored and a copy of your PHI will be mailed to you.
You have a ***right to request an amendment of PHI.*** If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
You have the ***right to know what disclosure(s) of your PHI have been made***. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to June 1, 2004 Updated: April 14, 2012.
You have a ***right to request confidential communications of PHI***. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
You have a ***right to request restrictions on the use and disclosure of PHI,*** however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
You have a ***right to receive a hard copy of this notice***. This notice can also be accessed on our website www.OlympicoChiro.com.

How will Olympico Chiropractic Clinic Use and Disclose PHI under HIPAA?
HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

- ***Disclosure to those Involved in the Individual's Care*** – when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.
- ***Uses and Disclosures Required by Law*** – as required by law we are required to use and disclose PHI for the following reasons:
- Use and Disclose PHI for Public Health Activities – Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
- Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
- Uses and Disclosure of Health Oversight Activities – we may use and release PHI to be used for audits, investigations, licensure issues, etc.
- Disclosure for Judicial and Administrative Proceedings – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.

•Disclosure for Law Enforcement Purposes – we may disclose *reasonably necessary* PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
•Uses and Disclosures Related to Decedents – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
•Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations – we may use and release PHI in order to facilitate organ, eye or tissue donations.
•Uses and Disclosures to Avert a Serious Threat to Health or Safety – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
•Uses and Disclosures for Specialized Government Functions – we may use and release PHI for military/veterans activities and national security/intelligence activities.
•Use and Disclosure of PHI in Emergency Situations - in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
•***Uses and Disclosures of PHI for Marketing Purposes*** – Olympico Chiropractic Clinic will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
•***Uses and Disclosures of PHI for Research Purposes*** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
•***Uses and Disclosures requiring the Patients Authorization*** - we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of The Olympico Chiropractic Clinic?
Olympico Chiropractic Clinic must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint?
If you feel your privacy rights have been violated, contact Olympico Chiropractic Clinic's Privacy Officer, Katie Werner, 630-261-9286 or contact the regional Department of Health and Human Services at 312-886-2359 or www.hhs.gov.

Receipt of Notice of Privacy Practices Form

Effective June 1, 2004 Updated: April 14, 2012

I, ___________________________, hereby acknowledge receipt of Olympico Chiropractic Clinic's Notice of Privacy Practices. Olympico Chiropractic Clinic will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Olympico Chiropractic Clinic has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.
I give my consent for Olympico Chiropractic Clinic to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Olympico Chiropractic Clinic.

Signed: ____ Date: ________________________

If you are not the patient, please specify your relationship to the patient ________________________.

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; It is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and chiropractic procedures, including various modes of physically therapy and physiotherapeutic medicine. The chiropractic treatment may be performed by Dr. Thomas George and/or other licensed Doctors of Chiropractic, Massage Therapists, or estheticians working in the clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for Dr. Thomas George.

I have had the opportunity to discuss with Dr. Thomas George my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatments, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic, physically therapy and physiotherapeutic medicine treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Surface bruising or redness
- ☐ Exercise, Vibration Shake Plate Fainting/injury
- ☐ Other ______________________________

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT
PLAN:____
____

I have read, or have had read to me, the above & below consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of my treatment for my condition.

To be completed by the patient:

____
print name

____
signature of patient

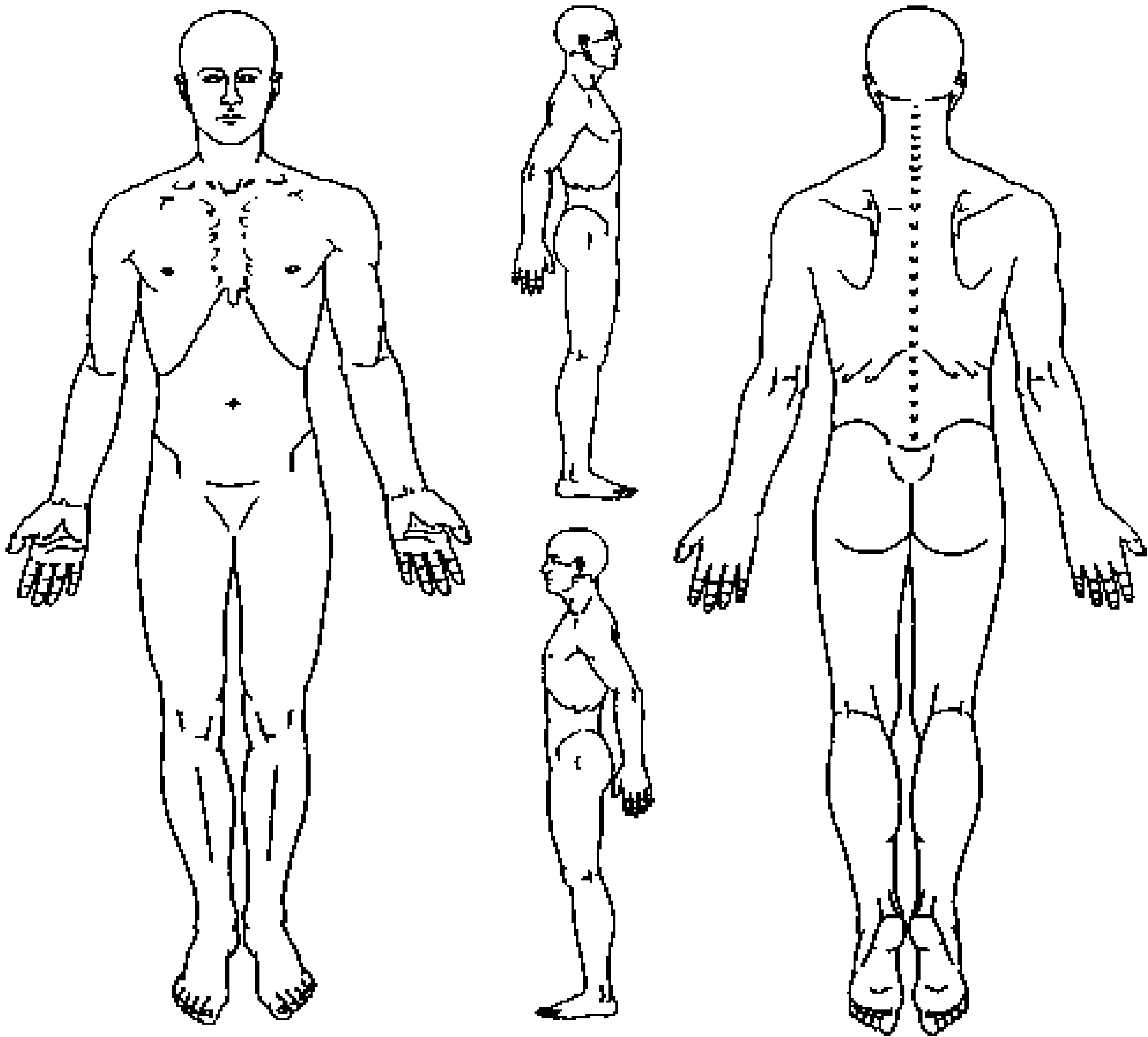
____
date signed

THE BACK & NECK DISABILITY INDEX QUESTIONNAIRE

NAME ____ DATE ___________

How long have you had Back/Neck pain _______ years ________ months _______ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE	**B = BURNING**	**N = NUMBNESS**
P = PINS & NEEDLES	**S = STABBING**	**O = OTHER**

OLYMPICO
• CHIROPRACTIC •
MED-SPA