East Vancouver Chiropractic & Massage PC

Chiropractic Massage Therapy Physical Rehab Wellness

Health Questionnaire

Name: _____ Home Phone: _____ Cellular Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____ How did you hear about us?_____

General History

Are you currently under Doctor's care? Yes_____ No_____ If Yes, specify:_____

Have you had Surgery in the last 9 Months? Yes____ No_____ If Yes, specify:_____

_____

Any Injuries? Yes____ No____ If yes, Specify:_____

Have you had any of the following conditions?

Tightness or Discomfort? Yes____ No____ If so, describe:_____

Herniated Discs? Yes____ No____

Headaches or Sinus trouble? Yes____ No____

Arthritis? Yes____ No____

Broken bones/Fractures? Yes____ No____

Backache? Yes____ No____

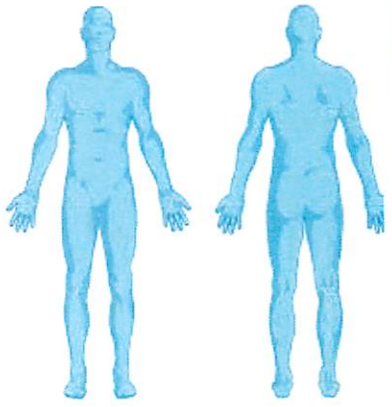
Neck/Shoulder Pain? Yes____ No____

Gas/Constipation/Diarrhea? Yes____ No____

Varicose Veins/Phlebitis? Yes____ No____

High or Low Blood Pressure? Yes____ No____

Allergies? Yes____ No____ If so, what kind:_____



Indicate areas of pain or recent surgery on drawing above.

Medications? (Please Specify) _____

Are you Pregnant? Yes____ No____
Do you wear contacts/Dentures? Yes____ No____
Do you smoke? Yes____ No____
Do you drink water daily? Yes____ No____
Do you exercise regularly? Yes____ No____
Have you had a Massage before? Yes____ No____

Would you be interested in receiving Massage Therapy more frequently if there was little to no Out of Pocket expense?

Yes____ No____ If so, please leave fill out your insurance information below and we will verify if you qualify.

Insurance Plan:_____ **Insurance Id #:**_____ **Insurance Phone Number:**_____
Insurance Group: _____ **Policy Holder's Name:**_____ **DOB:** _____

Signature:_____ Date:_____

Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations 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 health care 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 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 students, licensing, marketing, and fund raising activities, and conduction 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 situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the 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, in writing, 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.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name