

PATIENT INFORMATION

Today's Date: _____
Patient Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____

Marital Status: Single Married Other

Spouse's Name: _____ Date of Birth: _____
Social Security #: _____ Number of Children: _____ Employer: _____

PATIENT'S INSURANCE	SPOUSE'S INSURANCE <input type="checkbox"/> (Check if same)
Name of Company: _____	Name of Company: _____
Address: _____	Address: _____
ID & Group #: _____	ID & Group #: _____
Phone #: _____	Phone #: _____

What is your current major complaint: _____

Specific date of injury or illness: _____ None - (Gradual Onset)

How did the injury occur: Auto Accident On the job Other: _____

Does anything make the pain better: _____

Does anything make it worse: _____

Other Doctors seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? Yes No

If yes, please describe: _____

How did you hear about our office: _____

PLEASE FILL OUT THE INFORMATION BELOW ONLY IF YOUR VISIT IS RELATED TO AN AUTO ACCIDENT:

Please explain in detail how the accident happened: _____

Driver of other vehicle (if any): _____ Insurance: _____

Insurance Address: _____ Policy #: _____

Claim #: _____ Contact Person: _____

Driver of vehicle you were in (Self or other): _____

Insurance: _____ Address: _____

Policy #: _____ Claim #: _____ Contact: _____

Your attorney name and phone (if any): _____

Accident Information - Date occurred: _____ Time: _____ Location: _____

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Name: _____ Patient

Date: _____

MUSCULO-SKELETAL SYSTEM

- Low Back Pain
- Mid Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Problems
- Leg Problems
- Swollen Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Spasms
- Broken Bones

GENITO-URINARY SYSTEM

- Bladder Problems
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urine

FEMALES ONLY

- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain
- Lumps on Breast

ARE YOU PREGNANT?

- YES NO

GENITO-URINARY SYSTEM

- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Excessive Thirst
- Nausea
- Vomiting Blood
- Diarrhea
- Constipation
- Black Stools
- Bloody Stools
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Problems

CARDIO-VASCULAR RESPIRATORY

- Chest Pain
- Pain Over Heart
- Difficult breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problem
- Heart Problems
- Lung Problems
- Varicose Veins

EYE, EAR, NOSE AND THROAT

- Eye Strain
- Eye Inflammation

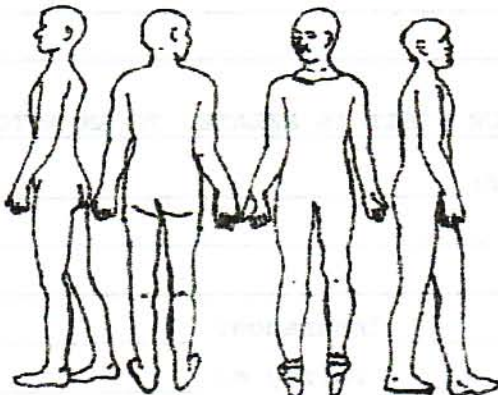
NERVOUS SYSTEM

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness/Vertigo
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia
- Vision Problems
- Ear Pain
- Tinnitus / Ear Ringing
- Ear Discharge
- Hearing Loss
- Nose Pain
- Nose Bleeding
- Nose Discharge
- Difficult Nose Breathing
- Dental Problems
- Sore Gums
- Sore Mouth
- Sore Throat
- Hoarseness

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee/Tea/Cokes
- Drug Abuse
- Difficult Speech
- Sinus Problems
- Allergies
- Jaw Pain

Symptom Localization



P - Pain
N - Numb
S - Spasm
T - Tender
B - Burning
H - Hypoesthesia

Pain Index (Circle One)

Least 1 2 3 4 5 6 7 8 9 10 Worst

Insurance Authorization/Release

Patient: _____ Date: _____

Please check any and all insurance coverage that may be applicable in this case.

___ Major Medical ___ Work Compensation ___ Medicaid
___ Medicare ___ Auto Accident ___ Other _____

Medicare/Medicaid ID #: _____ County: _____

Primary Insurance: _____ Family ___ Individual ___
Address: _____ Phone: _____
Group #: _____ Employer: _____
Insured Name: _____ DOB: _____ S.S.# _____

Secondary Insurance: _____

For Worker Compensation:

Date of injury: _____ Injury reported to employer? ___ Yes ___ No
Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____

If litigation is pending:

Attorney Name: _____
Address: _____
City: _____ State: _____ Zip: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits DIRECTLY to the chiropractor. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am responsible for all costs of chiropractic treatment, regardless of coverage.

(Signature of Insured Person)

(Date)

PATIENT INTRODUCTION CARD

No.: _____ Date: _____

Name (Mr. Mrs. Miss Ms.): _____ Phone (Home): _____
(Last, First, MI)

Address: _____
(City) (State) (Zip)

Cell Phone: _____ Email Address: _____

Married ____ Single ____ Other ____ Age ____ Date of Birth: ____ / ____ / ____

Occupation: _____ Employer: _____

Office Address: _____ Phone (Office): _____

Previous Chiropractic Care? ____ Yes ____ No Doctor's Name: _____

Name of your Insurance Company: _____

Major Complaint: _____ Social Security No.: _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Blanket Authorization

Blanket Authorization and Assignment:

I understand that the following authorizations and assignments are to be used by Nordstrom Chiropractic and all Physicians associated there with to effect the collections of benefits in my behalf; copies of this agreement will be as valid as the original. This information to you is an assignment of my rights under medical coverage to the extent of this bill.

Blanket Authorization to Release Information:

I authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinical services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patients') record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all clinic charges, including and not limited to hospital or medical service companies, insurance company workers, compensation carriers, welfare funds or the patients employee.

Assignment to Pay Insurance Benefits:

I hereby assign to Nordstrom Chiropractic the benefits payable under all plans of health insurance otherwise payable to me, but not to exceed the physicians' regular charge for the period of treatment. I further understand that I am responsible for payment of charges not covered by the assignment.

Legal/Collection Fee:

I agree to pay all reasonable fees to attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on my account. I also agree that if at any time there is need for legal action to be brought against any insurance company I will be responsible for instigating such action.

Print: _____ **Date:** _____

Signature: _____
(If patient is a minor, guardian must sign)

HIPAA Notice of Privacy Practices

**Nordstrom Chiropractic, PLLC
16135 N. May Ave, Ste B
Edmond, OK 73013
405-341-2126**

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" 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.

1. Uses and Disclosures of Protected Health Information

Your PHI 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 you, to pay your health care bills, to support the operation of the physicians practice and any other required law.

2. Treatment

We will use and disclose your PHI 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 PHI, as necessary to a home health agency that provides care to you. For example, your PHI 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.

3. Payment

Your PHI 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 PHI be disclosed to the health plan to obtain approval for hospital admission.

4. Healthcare Operation

We may use or disclose, as needed, your PHI 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, and training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical 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 PHI as necessary, to contact you to remind you of your appointment. We may also use your name in addressing birthday and/or referral thank you cards.

We may use or disclose your PHI in the following situations without your authorization. These situations include: Abuse or Neglect; Food and Drug Administration requirements; Research; Criminal Activity; Military activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to and 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 the authorization at any time, in writing, except to the extent that your physician or the physicians' practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with the respect to your PHI.

You have the right to inspect and copy your PHI

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

You have the right to request a restriction of your PHI

This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operation. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions request and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication 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 PHI

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 and accounting of certain disclosures we have made, if any, of your PHI.

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 privacy rights have been violated by us. You may file a complaint with us by notifying your privacy contract of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **December 30, 2004.**

WE are required by law to maintain the privacy of, and provide individual with this notice of legal duties and privacy practices with respect to PHI. 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.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Name _____

Signature _____ Date _____