



Health Analysis

Patient Name: _____ Age _____ Date _____

**** Please Circle the Appropriate Answer ****

- Have you been diagnosed with any of the following medical conditions:
Arthritis Cancer Diabetes Heart Disease Hypertension Psychiatric illness Skin Disorder
Stroke Other _____
- Have you ever had major surgery? Yes No
If yes, please specify: _____
- Do you have any allergies? Yes No
If yes, please specify: _____
- Do you use caffeine? Occasionally Often Never
- Do you drink alcohol? Occasionally Often Never
- Do you exercise? Occasionally Often Never
- Do you smoke? More than 1 pack a day
Less than 1 pack a day
Never
- Do you experience stress? Occasionally Often Never
- Do you wear your seatbelt? Occasionally Often Never
- Are any of the following conditions present in your family history? If so, please specify.
Arthritis parent / sibling / other _____
Cancer parent / sibling / other _____
Cholesterol parent / sibling / other _____
Diabetes parent / sibling / other _____
Heart Problems parent / sibling / other _____
High Blood Pressure parent / sibling / other _____
Thyroid parent / sibling / other _____
Stroke parent / sibling / other _____
Psychiatric parent / sibling / other _____

Health Analysis

22. During the past 4 weeks, how much has pain interfered with your normal life?
Not at all A little bit Moderately Quite a bit Extremely
23. During the past 4 weeks, how much has pain interfered with your social activities?
Always Most of the time Some of the time A little of the time None
24. In general, you would say your overall health is...
Excellent Very good Good Fair Poor
25. Who have you seen for your symptoms?
No one Other Chiropractor Medical Doctor Physical Therapist Other
26. What treatment did you receive for your symptoms?
Adjustments Physical therapy Medication Surgery Other
27. How long since you received this treatment?
Less than 30 days 2 - 3 months 3 - 6 months 6 months-1 year 1 - 2 years
2 - 5 years 5 - 10 years
28. What tests have you had performed for your symptoms?
X-Ray MRI CT Scan Other
29. How long since these tests done?
Less than 30 days 2 - 3 months 3 - 6 months 6 months-1 year 1 - 2 years
2 - 5 years 5 - 10 years
30. Have you had similar symptoms in the past? Yes No
31. If you have received treatment in the past for the same or similar symptoms, who did you see?
This Office Other Chiropractor Medical Doctor Physical Therapist Other
32. If you are not retired, a homemaker, or a student, what is your current work status?
Full-time Part-time Self-employed Unemployed Off work Other

Thank you !

New Patient Introduction

Date: _____

Name: _____

Home Phone: _____

Address: _____

Social Security#: _____ Cell Phone: _____

Email Address: _____ DOB: _____

Marital Status: _____ Age: _____

Occupation: _____ Employer: _____

Office Address: _____

Office Phone: _____

Previous Chiropractic care? ___Yes ___No

Doctor's Name: _____

Name of your insurance company: _____

Who (or what source) referred you? _____

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.

Bair Chiropractic, PLLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at the office please contact the office at (405) 533-1151

I. How Bair Chiropractic, PLLC may Use or Disclose Your Health Information

Bair Chiropractic, PLLC collects health information from you and stores it on a computer. This is your medical record. The medical record is the property of Bair Chiropractic, PLLC, but the information in the medical record belongs to you. Bair Chiropractic, PLLC protects the privacy of your health information. The law permits Bair Chiropractic, PLLC to use or disclose your health information for the following purposes:

1. Treatment. We may disclose information regarding your treatment to other health care providers who have requested information pertaining to your treatment.
2. Payment. In the event that your health insurance company should need specific information regarding your health care in order to issue payment, we will provide the information to the entity issuing the request.
3. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
4. Required by law. As required by law, we may use and disclose your health information.
5. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
6. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
7. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
8. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
9. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
10. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
11. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.
13. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services.
14. Change of Ownership. In the event that Bair Chiropractic, PLLC is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When Bair Chiropractic, PLLC May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Bair Chiropractic, PLLC will not use or disclose your health information without your written authorization. If you do authorize Bair Chiropractic, PLLC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Bair Chiropractic, PLLC is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that Bair Chiropractic, PLLC amend your health information that is incorrect or incomplete. Bair Chiropractic, PLLC is not required to change your health information and will provide you with information about Bair Chiropractic, PLLC denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by Bair Chiropractic, PLLC, except that Bair Chiropractic, PLLC does not have to account for the disclosures described in parts 1 (treatment) and 2 (payment) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Bair Chiropractic, PLLC 4721 W. 6th Ave. Suite 120, Stillwater, OK 74074

IV. Changes to this Notice of Privacy Practices

Bair Chiropractic, PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Bair Chiropractic, PLLC is required by law to comply with this Notice. In the event that is notice is changed a copy of the revised version will be mailed to the address we have on file.

V. Complaints

Complaints about this Notice of Privacy Practices or how Bair Chiropractic, PLLC handles your health information should be directed to Bair Chiropractic, PLLC 4721 W. 6th Ave. Suite 120, Stillwater, OK 74074

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at <http://www.hhs.gov/ocr/regmail.html>

DR. BAIR'S OFFICE POLICY

Patient Name _____

OFFICE: We believe that a clear definition of our office policies will allow us to concentrate on "The Big Issue" REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of our office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know.

Initials _____ **AUTHORIZATION FOR PAYMENT:** It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us.

1. The privilege of insurance assignment begins when our office receives your insurance forms and coverage has been verified.
2. If filing insurance, I hereby authorize Dr. Bair to furnish any and all medical records that my insurance company may request for payment of my charges.
3. If I am choosing not to file insurance, I understand that I am expected to make payment at the time of service and agree to make payment in accordance with this policy.

Initials _____ **PHONE CONTACT:** Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, follow thru medical information, treatment alternatives, or other health related information. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By initialing you are giving us authorization to contact you and to leave messages on your answering machine or with individuals at your home or place of employment.

Initials _____ **INFORMED CONSENT:** The patient has been informed and understands that the practice of chiropractic includes treatment by manipulation of the patient's body, including the spine. Manipulation of the body and the spine necessarily involves applying pressure, by the use of "hands on" techniques which require Dr. to use his hands and body to cause appropriate movement within the patient's body. Manipulation by a chiropractor should not cause damage to the patient.
Manipulation of the patient by the chiropractor will necessarily involve physical contact between Dr. Bair and the patient. The patient acknowledges that the general nature of this physical contact has been explained to them by Dr. Bair prior to commencement of treatment and examination. During treatment Dr. Bair may touch the patient's body in a variety of areas including near the patient's groin, the patient's buttock, and near the patient's breasts. If the patient feels that such potential for contact may be distressing or uncomfortable the patient should either avoid chiropractic treatment with this chiropractor or, in writing request that an attendant observer be present during treatment and examination, subject to any applicable charge.
If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs, you will immediately inform Dr. Bair and give him sufficient notice to allow him to alter the treatment plan as appropriate.

Initials _____ **THANK YOU CARDS:** When you refer a friend, family member or colleague to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a thank you card.

Initials _____ **REFERRAL BOARD:** When you refer a friend, family member or colleague to our office, we would like to put your first name **ONLY** on our referral board, thanking you for sending that person to our office. By signing this form you are giving us authorization to display your name on our board.

Initials _____ **FINANCIAL ARRANGEMENTS:** We have an open front desk and many of our financial arrangements are discussed at the front counter. Please do not initial this if you would prefer to have your financial arrangements discussed in a more private place.

I have read and fully understand all of the above information. I acknowledge that I have read or received a copy of Dr. Bair's Notice of Privacy Practices. I also understand that my refusing to sign this form means that I will not be treated at this office.

Patient's Signature _____ **Date** _____

Guardian's Signature Authorizing Care for Minor _____