CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

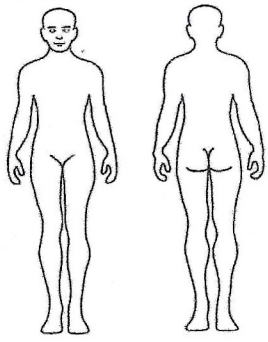
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Informed Consent

Patient Name_____ **Date**_____

We will use our hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of the adjustment.

We are aware of these complications, and in order to minimize their occurrence we will take every precaution. These precautions include, but are not limited to our taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x- rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell us when we take your clinical history.

_____ _____

Date Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

_____

Doctor's Signature

Radiant Life Chiropractic, PLLC
17236 N May Ave Ste A
Edmond, OK 73012
405-562-3199

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

I hereby authorize medical providers and personnel of Radiant Life Chiropractic, PLLC to discuss and/or release my protected health Information with: (Please note that If the patient Is a minor, each parent or guardian needs to be listed.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I have the right to revoke this authorization, In writing, at any time. I understand that Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____

Signature

_____

Date

RADIANT LIFE Chiropractic

Payment Policy & Agreement

Payment is required the same day services are rendered unless other arrangements have been made prior to seeing the doctors. Patients are responsible for all charges on his or her account.

Assignment will be accepted on primary and secondary insurance. Please provide your insurance information if you prefer we bill your insurance. We will make every effort to verify your insurance coverage. No insurance carrier guarantees payment. You are responsible for knowing the terms of your insurance policy.

A family discount plan is available for individuals without insurance or choose not to use his or her insurance. Please ask for details.

A payment plan option is available if agreed upon by the patient and Radiant Life Chiropractic.

No Show/No Call Policy if the patient no shows his or her appointment or does not call at least 24 hours prior to the appointment to cancel or reschedule 3 times, a no show/no call fee of $50 will be added to the patient's account. This fee must be paid prior to being allowed to schedule any future appointments.

Authorization

I authorize release of all information regarding my condition to any insurance co., attorney, or adjuster to process any claims for reimbursement and release you of any consequences thereof. I transfer to you the cause of action that exists in my favor to act on my behalf to resolve any insurance claim and direct any insurance plan or benefit obligated to reimburse me for covered services to make payment directly to the provider at Radiant Life Chiropractic.

Verification of benefits and information an insurance carrier provides is not a guarantee of payment and the patient is responsible for all charges incurred.

A statement will be mailed to the patient if a balance is remaining following all collected copays, coinsurance, and insurance payments. Every effort will be made to collect payment from the patient. If the balance is not paid in full, or we have not heard from the patient or guarantor to set up a payment plan, following 3 mailed statements, the account will be sent to collections. Any legal fees incurred due to this action will be added to the remaining balance.

I understand I will be responsible for payment of services in full if it is determined either a) the insurance listed is not obligated to pay for the services, b) the insurance company refuses to acknowledge an assignment to Radiant Life Chiropractic, c) charges are not paid in amount verified at initial visit.

_____ _____

Patient signature/ or guardian Date Witness Date

Radiant Life
CHIROPRACTIC

CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT

Name of Patient: _____

Date of Birth: _____

I, _____, am the parent/guardian of the above patient. **I have the legal right to consent for medical treatment for this child.**

I authorize the following individual(s), who is over 18 years of age, to bring the child to his or her medical appointment, and to consent to medical care which is deemed necessary by the physician(s) at Radiant Life Chiropractic. I understand that this delegation includes receiving health information about the minor necessary to make immediate necessary health care decisions.

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

This consent is valid until revoked in writing by me, the parent or legal guardian.

Signature of Parent or Guardian: _____

Printed Name: _____ Date: _____

Radiant Life Chiropractic, PLLC

PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USE AND DISCLOSURE OF INFORMATION

1) The Practice may use and/or disclose your PHI for the purposes of:
   a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.
   b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
   c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.
2) The Practice may also use and/or disclose your PHI in the following instances:
   a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
   b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
   c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
   d) Emergency Situations –
      i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your acknowledgement of our Privacy Notice as soon as possible; or
      ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
   e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your acknowledgement of our Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.
   f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.
   g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
   h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
   i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
   j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
   k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
   l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
   m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
   n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
   o) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.
   p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
   q) National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
   r) Military and Veterans – If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

3) **APPOINTMENT REMINDER, CHIROPRACTIC BULLETIN, BIRTHDAY, & REFERRAL THANK YOU**

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard or bulletin mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone and c) all electronic communications via reminder servicing vendor. The Practice recognizes patient birthdays and sends referral thank you cards (listing the patient referred) by mailing a postcard to you at the address provided by you.

4) **DIRECTORY/SIGN-IN LOG**

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

5) FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

6) AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

7) YOUR RIGHTS

You have the right to:

a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.
e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before December 03, 2018. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Jessica Ray, 17236 N May Ave Ste A, Edmond, OK 73012 or (405)562-3199.

8) PRACTICE'S REQUIREMENTS

The Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
b) Is required to abide by the terms of this Privacy Notice.
c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
d) Will distribute any revised Privacy Notice to you prior to implementation, if specifically requested by you. Otherwise, it will be distributed at your next visit, and will be available upon request. We will also distribute it by
e) E-mail if you give us your E-mail address.
f) Will not retaliate against you for filing a complaint.

9) EFFECTIVE DATE:

This Notice is in effect as of 12/03/2018.