Proactive Chiropractic PLLC

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Proactive Chiropractic, PLLC
1539 Crescent Road
Clifton Park, NY 12065
P: 518.373.9999
F: 518.373.8887
email: info@chiro1539.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender ○ Male ○ Female

Birth Date (MM/DD/YYYY)

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City **State/Province** **ZIP/Postal Code**

Preferred Language

Home Phone **Cell Phone**

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact **Emergency Contact's Phone**

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City **State/Province** **ZIP/Postal Code**

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

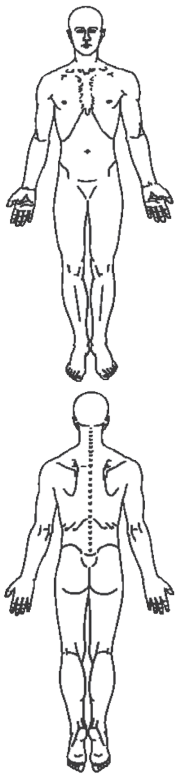
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Proactive Chiropractic know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Proactive Chiropractic, PLLC

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes	No	
○	○	If Yes please list: _____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Proactive Chiropractic about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○
_____	_____	○	○	_____	_____	○	○

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Proactive Chiropractic about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Doctor's Initials

Proactive Chiropractic, PLLC

12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature _____

Date (MM/DD/YYYY) _____

Consultation Notes

Patient name _____

Patient Number
(office use only) _____

Doctor's Initials _____

Proactive Chiropractic, PLLC

Name _____**Date**_____

Current Health Concern _____
Date of Onset _____
Cause of Injury _____

Pain description

- ❑Ache
- ❑Burning
- ❑Cramp
- ❑Deep
- ❑Dull
- ❑Local
- ❑Numbness
- ❑Pin Point
- ❑Radiating
- ❑Referred
- ❑Sharp
- ❑Shooting
- ❑Spasm
- ❑Stabbing
- ❑Tingling
- ❑Throbbing

Length of day in pain

- ❑Intermittent (<25%)
- ❑Occasional (>25%)
- ❑Frequent (>50%)
- ❑Constant (>75%)

Pain interference with activities

- ❑Minimal (annoy)
- ❑Slight (tolerate)
- ❑Moderate (impair)
- ❑Marked (preclude)

What makes it better?

- ❑Having adjustments
- ❑Hot showers
- ❑Massage
- ❑Rubbing heat liniment
- ❑Rubbing mineral ice
- ❑Taking OTC Meds
- ❑Taking Rx Meds
- ❑Other _____
- ❑Heat
- ❑Ice
- ❑Resting
- ❑Sitting
- ❑Sleeping
- ❑Walking
- ❑Tub soaking

What makes it worse?

- ❑Arising from a chair
- ❑Carrying
- ❑Climbing a ladder
- ❑Climbing stairs
- ❑Exercising
- ❑Getting in & out of car
- ❑Getting out of bed
- ❑Pushing
- ❑Repetitious movements
- ❑Sleeping
- ❑Stress
- ❑Walking
- ❑Walking uphill
- ❑Looking up or down
- ❑Turning head L or R
- ❑Bending
- ❑Cold
- ❑Coughing
- ❑Driving
- ❑Heat
- ❑Lifting
- ❑Pulling
- ❑Reclining
- ❑Sitting
- ❑Standing
- ❑Throwing

Related problems

- ❑Back ache
- ❑Chest pain/tightness
- ❑Difficulty-urination
- ❑Dizziness
- ❑Flank pain
- ❑Groin pain
- ❑Headache
- ❑Intestinal pain
- ❑Nausea
- ❑Pain- defecation
- ❑Pain- urination
- ❑Ringing in ears
- ❑Short of breath
- ❑Shoulder pain
- ❑Stomach ache
- ❑Visual disturbance
- ❑Vomiting
- ❑Difficulty- urination

Have you ever experienced this pain before?

❑Yes ❑No

If yes, when and what was the outcome?

_____

Allergies: ❑Yes ❑No
Smoker: ❑Yes ❑No

Care to date

- ❑None
- ❑OTC Meds
- ❑Other HCP
- ❑Rest
- ❑Rx Meds
- ❑Self
- ❑Surgery
- ❑Physical Therapy

Testing

- ❑X-ray
- ❑CT Scan
- ❑MRI
- ❑Ultrasound

Results _____

Current Status

- ❑Worsening
- ❑No change
- ❑Moderate
- ❑Improving
- ❑Slight
- ❑Significant

Goals for care

- ❑Symptom relief
- ❑Prevention
- ❑Rehabilitation
- ❑All

Please rate your pain on a scale from 0 - 10 at this moment
(0 = no pain and 10 = worst possible pain)

0——1——2——3——4——5——6——7——8——9——10

The Primary Care Low Back Disability Questionnaire (PCLBDQ)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/_____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please **circle the choice which most closely describes your problem**.

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is very severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change may way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weight without extra pain.
B. I can lift heavy weight, but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain on standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed but it doesn't prevent me from sleeping well.
C. Because of my pain my normal night's sleep is reduced by <¼.
D. Because of my pain my normal night's sleep is reduced by <½.
E. Because of my pain my normal night's sleep is reduced by <¾.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted by social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening

Office Use Only PCLBDQ SCORE: _____

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature_____ Date_____

Proactive Chiropractic PLLC

HEALTHCARE INFORMATION PRIVACY POLICIES & PRACTICES
H.I.P.P.A. of 1996, 45 CFR Parts 160 & 164

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW CAREFULLY.

OUR LEGAL DUTY:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect March 3, 2003 and remains in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION:
We use and disclose health information about you for treatment, payment, and healthcare operations. We will not use or disclose your information for purposes not listed below.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include (but not limited to): electric medical record operations and security, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except described in this notice.

Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We my use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we may charge you $1.00/page and postage if you want your copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that form. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed below for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before March 3, 2003. If you request this accounting more than once in 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. The designated Privacy Officer to whom you should address your concerns is Anne-Marie Nelson, D.C. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed below. You may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information:

Anne-Marie Nelson, D.C.
Proactive Chiropractic, PLLC
1539 Crescent Road
Clifton Park, NY 12065-7701
P: (518) 373-9999

Revised September 20, 2017

Proactive Chiropractic PLLC
1539 Crescent Road, Clifton Park NY 12065
Phone: 518.373.9999 & Fax: 518.373.8887

ACKNOWLEGDMENT OF RECIEPT OF NOTICE OF HEALTHCARE INFORMATION PRIVACY POLICIES AND PRACTICES

** You may refuse to sign this acknowledgement**

"I have been given an opportunity to review this offices Healthcare Information Privacy Policies & Practices"

Print Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Healthcare Information Privacy Policies and Practices, but we were unable to do so because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other (please specify)

_____

Proactive Chiropractic PLLC

1539 Crescent Road, Clifton Park, NY 12065

PATIENT INFORMED CONSENT

All health care professionals (anesthesiologist, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any risks of treatment, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications.

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise of a cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/ or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical muscle stimulation, hot/cold therapy and therapeutic ultrasound. There are risks, although rare, of fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains or death through complicating factors. With respects to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of the artery that may cause the development of a thrombus (clot) with the potential of causing a stroke. This may occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association between neck manipulation and vertebral artery dissection is estimated to be less than 1 in 1,000,000 (1).

Chiropractic care does not use drugs or surgery. This practice is staffed with graduate chiropractors that are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is a system of noninvasive therapy that holds that certain musculoskeletal disorders result from nervous system dysfunction arising from misalignment of the spine and joints. Treatment focuses on manual adjustment or manipulation of the altered joints. Your treatment may also include exercise, therapeutic ultrasound, electric muscle stimulation, soft tissue techniques and/or low-level laser therapy (LLLT). This practice often addresses the relationship of the joint dysfunction and the surrounding soft tissue and how it relates to biomechanical changes throughout the body.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

I have read, or had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I hereby accept the risks associated with any care by the doctors and staff at this office and release Proactive Chiropractic, PLLC of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff of Proactive Chiropractic, PLLC permission to provide emergency care and any follow-up necessary, including Emergency Medical Services. I intend this consent to cover the entire course of care from all the providers in this office for my present condition and for my future condition(s) for which I seek chiropractic treatment from this office.

Patient Name Printed: _____ Date: _____

Patient/ Guardian Signature (if minor): _____

1. Haldeman S, Carey P, Townsend M, Papadopoulos C: Arterial dissections following cervical manipulation: the chiropractic experience. CMAJ 2001;165:905.

Doctor's Signature: _____ Date: _____

Patient Financial Responsibility Disclosure and Acknowledgment

Your signature on the line below forms a legally binding agreement between Proactive Chiropractic, PLLC and the undersigned patient (the "Patient") who is receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Proactive Chiropractic, PLLC, and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service.**

Proactive Chiropractic, PLLC has contracts with numerous third party insurance companies and Proactive Chiropractic, PLLC will bill such third party insurance companies for services rendered to you by Proactive Chiropractic, PLLC as a service to you. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason whatsoever. The Responsible Party shall also be responsible for making any and all required co-pays and deductibles. The Responsible Party shall also be responsible for paying any additional amount owing after claim submission to the Patient's insurance and will be billed for any such deficit after Proactive Chiropractic, PLLC receives an explanation of benefits (EOB) from the Patient's insurance company.

The Responsible Party shall:

- Provide, and update to maintain current, the Responsible Party's current address and phone number for both the Responsible Party and the Patient.
- Present all current insurance cards prior to each of the Patient's office visits.
- Verify at each office visit that the information, including address, phone number, and insurance information is accurate and current by signing Proactive Chiropractic, PLLC's data sheet.
- Pay any required co-pay at the time of each office visit.
- Pay any additional amount owing within thirty (30) days of receiving a statement from Proactive Chiropractic PLLC; it being understood that Proactive Chiropractic, PLLC will bill the Responsible Party for any amounts not paid by the insurance company as set forth on the EOB received from the Patient's insurance company.

Returned Checks – If payment is made by check and the check is returned unpaid for insufficient funds, or unpaid for any other reason, the Responsible Party shall be financially responsible to Proactive Chiropractic, PLLC for the original face amount of the returned check plus a service charge equal to $25.00 (the "Service Charge"). If payment of the face amount of the check plus the Service Charge is not received within 15 days of notification, then Proactive Chiropractic, PLLC may turn the account over to Proactive Chiropractic, PLLC's collection agency for collection of the same. The Responsible Party shall be responsible for all costs of collection in addition to the face amount of the check and Service Charge.

Non-Payment – In the event that Proactive Chiropractic, PLLC should initiate collection proceedings or other legal action to collect an overdue account, the Patient and Responsible Party each acknowledge and understand that Proactive Chiropractic, PLLC has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable service charges and applicable costs of collections. You agree to reimburse Proactive Chiropractic, PLLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including attorneys' fees, we incur in such collection efforts.

Patient Signature: _____ Date:_____

Responsible Party Signature (if patient is a minor): _____ Date: _____