

DERIK S ANDERSON, D C

Patient Information

All Lines and Pages MUST be Completed

Name of Patient _____ Date of Birth ____ / ____ / ____

Address _____ Social Security # ____ / ____ / ____

_____ Age ____ # of children ____

Marital Status S M D W Occupation _____

Telephone (best) _____ Medical Doctor _____

Email _____ Referred by _____

SYMPTOMS (Please circle all that apply)

- HEAD: ▲ standing ▲ sitting ▲ bending
Loss of ▲ memory ▲ hearing ▲ balance
Light-headedness Dizziness Fainting Light bothers eyes Ringing in ears
NECK: Stiff neck Grinding sounds Arthritis
BACK: Pain is worse when: ▲ lifting
ABDOMEN: Nervous stomach Nausea Gas Constipation Diarrhea
SHOULDERS: Can't raise arm above ▲ shoulder level ▲ over head
ARMS & HANDS: Numbness of arm R/L
Numbness of hand R/L Fingers go to sleep Hands cold Swollen fingers R/L Sore joints R/L Arthritis
CHEST: Shortness of breath Pain around ribs
HIPS, LEGS & FEET: Leg cramps Numbness of leg R/L
Numbness of feet R/L Feet cold Cramps in feet R/L Swollen ankles R/L Swollen feet R/L
GENERAL: Nervousness Irritable Depressed Fatigue Generally feel run-down Loss of sleep Loss of weight Weight gain

WOMEN ONLY:

Menstrual Pain Cramping Irregularity Date of last period? _____ Are you now pregnant / possibly pregnant? Y/N

My goal with this treatment is to:

Get rid of pain

Resolve the cause of the pain

Have you had X-Rays taken in the past three years? Yes No What area? _____

Personal history and dates of illnesses / diseases _____

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Cancellations

To reschedule an appointment without charge you must call the office 24 hours in advance. For therapy visits (e.g. massage, Pilates, etc), you must call 72 hours in advance. Otherwise, you will be charged for the missed appointment. This must be paid by the patient. Appointments must be rescheduled within three days of the originally scheduled appointment.

Minors

If the patient is a minor (under the age of 18), I, the parent or legal guardian of the patient named at the top of this form, give full legal consent for Derik S. Anderson, DC to treat him/her. I also acknowledge that I am fully responsible for all charges incurred for this treatment and will pay them in a timely and prompt manner.

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Derik Anderson and/or other licensed doctors of chiropractic who now or in the future work at the office listed on this form or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPAA

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

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2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) via email to the email that I have provided in this intake form packet or otherwise, written or electronically, to The Practice.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I authorize The Practice to communicate electronically with me via email, at the address provided in this patient intake packet or via another email address I have provided, either written or electronically.
8. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Legal Guardian or Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____