Princeton Spine, Disc & Chiropractic Care, LLC

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation and how you may obtain access to that information. In addition, we are providing you with a list of potential circumstances under which by law, or in accordance with our office policy, we **may** disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this 'Notice' please sign the last page and return only the signature page (page 3) to our front desk receptionist.

PERMITTED DISCLOSURES

1. For treatment purposes- discussion with other health care providers involved in your care
2. *Inadvertent disclosures- services may be rendered in an open treating area, which means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.*
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
8. To Government agencies or Law enforcement, to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefit purposes.
10. Deceased persons –discussion with coroners, medical examiners and family members or others who were involved in the care or payment for care of the decedent prior to death,
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or up coming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI
13. To send communications while you are being treated and we are receiving financial remuneration
14. Speaking with the patient's guardian or representative regarding bill payment
15. Providing therapy to patients in group settings
16. We may discuss your PHI using personal mobile phones when necessary to facilitate discussion about your care and or record keeping of your care.

Any other uses of disclosures not described in the Notice of Privacy Practices will be made only after obtaining your prior written authorization.

Note: ***At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.***

Princeton Spine, Disc & Chiropractic Care, LLC

YOUR RIGHTS

1. To receive an accounting of disclosures
2. To receive a paper copy of a more detailed /comprehensive Privacy Notice
3. To request mailings to an address different than your residence
4. You have the right to request and receive electronic copies of your records
5. To request amendments to information, however like restrictions we are not required to agree to them
6. You have the right to receive notification in the event of a breach of unsecured PHI
7. To request restrictions on certain uses and disclosures and, however we are not required to comply with your request.
8. With advance notice of at least five business days to the practice you may inspect your records and receive one copy of your records at no charge.
9. You have the right to request and we as a covered entity will restrict disclosure of your personal health information to a health plan if disclosure pertains to a healthcare item or service, which you have personally, paid out of pocket for in full.
10. You have the right to NOT receive communications regarding fund raising and none will be sent to you unless you give us written authorization

ADDITIONAL RESPONSIBILITIES OF THIS PRACTICE

1. We are required to obtain a separate signed authorization from you before your personal health information can be used in marketing and for any disclosures that constitute a sale of personal health information.
2. We are required to notify you and HHS in the event of a breach caused by any of our business associates.
3. We are responsible to look over our business associate contracts to ensure they comply with the Omnibus Rules and requirements.
4. With prior authorization from you, we may contact you to send you information concerning products or services and information related or unrelated to your health.

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Angela Powell at 480-570-4204. If she is unavailable, you may make an appointment with our receptionist to see the Doctor within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

***Continued* from page 2 of 3 →** *Patient initials* __________.

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Patient:____ DOB: ________________

My signature below is an acknowledgement that I have received a copy of ***Princeton Spine Disc & Chiropractic Care, LLC Patient Privacy Notice.*** I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of this information to the doctor and do not have any question regarding my rights or any of the information I have received at this time.

I have been made aware that additional information regarding HIPAA and my rights is published in government newsletters, which are available to me online.

The first two original pages of this 'Notice' have been given to me to keep.

Patient signature Date

Witness Date

Print Witness Name Date

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Princeton Spine, Disc & Chiropractic Care, LLC
Initial Visit Intake

Today's Date: ________________

PATIENT DEMOGRAPHICS **E-Mail: ____**

Name: ____Birth Date: _____-_____-_____ Age: _______□ Male □ Female

Address: ____ City: _______________________State: _____ Zip: ___________

Home Phone: ___________________________ Cell Phone: ___________________________ Cell Phone Carrier: ___________

How did you hear about us: Google, Yelp, Insurance, Health Talk, Referral, if yes, who may we Thank? _____________________

____

Social Security #: _________________________________Driver's License #: ____

Employer name and Address: ____

____

Occupation: ____

Name of Spouse: ____

Occupation: _______________________________________ Names and Ages of your children: _________________________

____

Name & Number of Emergency Contact: ____

Relationship: ____

Have you ever been under chiropractic care? □ No □ Yes **If yes,** how long ago: ______________________________________

Name of Previous Chiropractor: ____

Are any of your problem(s) today the result of ANY **recent accident**? □ No □ Yes **If yes,** how long ago? __________________

Please explain what type of accident: ____

Do we have your permission to speak and discuss your findings with your Primary Care Physician: Yes_________No__________

Name & Number of Primary Care Physician: ____

HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

Primary problem____

When did the problem/symptom begin? ____

Number of times you have experienced this problem: ___________ Past 1 Week / 2 Week / 3 Weeks / 4 Weeks / _____ days /_____ Months

When was the last episode? ____

What relieves your symptom(s)? ____

What makes them feel worse? ____

Please mark with:
a "C" if you feel your pain constantly (symptoms presents 76% to 100% of time), or
a "F" if you feel your pain is frequent (symptom presents 51% to 75% of time) or
an "O" if you feel your pain is occasional (symptom presents 26% to 50% of time) or
an "I" if you experience it intermittently (symptom presents 1% to 25% of time)

On a scale of 1 to 10 with 10 being the absolute worst pain and 0 being no pain, rate how you feel when problem is at its worse ***(Circle the number)***: 0 1 2 3 4 5 6 7 8 9 10

Does your symptom cause you to feel worse in the □ AM □ PM □ mid-day □ late PM

Has this Problem ever been treated by anyone in the past? □No □Yes If yes,

Who provided: ____How long ago? _______________

What type of treatment did you receive? ____

What were the results? □ Favorable □ Unfavorable □ If unfavorable please explain:_____________________________

List any medications taken to treat this condition: ____

Did they help? □ No □ Yes If you still take them, how often? ____________________________________

2nd problem ____

When did the problem/symptom begin? ____

Number of times you have experienced this problem: ___________ Past 1 Week / 2 Week / 3 Weeks / 4 Weeks / _____ days /_____ Months

When was the last episode? ____

What relieves your symptom(s)? ____

What makes them feel worse? ____

Please mark with:
a "C" if you feel your pain constantly (symptoms presents 76% to 100% of time), or
a "F" if you feel your pain is frequent (symptom presents 51% to 75% of time) or
an "O" if you feel your pain is occasional (symptom presents 26% to 50% of time) or
an "I" if you experience it intermittently (symptom presents 1% to 25% of time)

On a scale of 1 to 10 with 10 being the absolute worst pain and 0 being no pain, rate how you feel when problem is at its worse ***(Circle the number)***: 0 1 2 3 4 5 6 7 8 9 10

Does your symptom cause you to feel worse in the □ AM □ PM □ mid-day □ late PM

Has this Problem ever been treated by anyone in the past? □No □Yes If yes,

Who provided: ____How long ago? _______________

What type of treatment did you receive? ____

What were the results? □ Favorable □ Unfavorable ☐ If unfavorable please explain:____

List any medications taken to treat this condition: ____

Did they help? □ No □ Yes If you still take them, how often? ____

3rd problem ____

When did the problem/symptom begin? ____

Number of times you have experienced this problem: ___________ Past 1 Week / 2 Week / 3 Weeks / 4 Weeks / _____ days /_____ Months

When was the last episode? ____

What relieves your symptom(s)? ____

What makes them feel worse? ____

Please mark with:
a "C" if you feel your pain constantly (symptoms presents 76% to 100% of time), or
a "F" if you feel your pain is frequent (symptom presents 51% to 75% of time) or
an "O" if you feel your pain is occasional (symptom presents 26% to 50% of time) or
an "I" if you experience it intermittently (symptom presents 1% to 25% of time)

On a scale of 1 to 10 with 10 being the absolute worst pain and 0 being no pain, rate how you feel when problem is at its worse ***(Circle the number)***: 0 1 2 3 4 5 6 7 8 9 10

Does your symptom cause you to feel worse in the □ AM □ PM □ mid-day □ late PM

Has this Problem ever been treated by anyone in the past? □No □Yes If yes,

Who provided: ____How long ago? _______________

What type of treatment did you receive? ____

What were the results? □ Favorable □ Unfavorable ☐ If unfavorable please explain:____

List any medications taken to treat this condition: ____

Did they help? □ No □ Yes If you still take them, how often? ____

4th problem ____

When did the problem/symptom begin? ____

Number of times you have experienced this problem: ___________ Past 1 Week / 2 Week / 3 Weeks / 4 Weeks / _____ days /_____ Months

When was the last episode? ____

What relieves your symptom(s)? ____

What makes them feel worse? ____

Please mark with:
a "C" if you feel your pain constantly (symptoms presents 76% to 100% of time), or
a "F" if you feel your pain is frequent (symptom presents 51% to 75% of time) or
an "O" if you feel your pain is occasional (symptom presents 26% to 50% of time) or
an "I" if you experience it intermittently (symptom presents 1% to 25% of time)

On a scale of 1 to 10 with 10 being the absolute worst pain and 0 being no pain, rate how you feel when problem is at its worse ***(Circle the number)***: 0 1 2 3 4 5 6 7 8 9 10

Does your symptom cause you to feel worse in the □ AM □ PM □ mid-day □ late PM

Has this Problem ever been treated by anyone in the past? □No □Yes If yes,

Who provided: ____How long ago? ______________

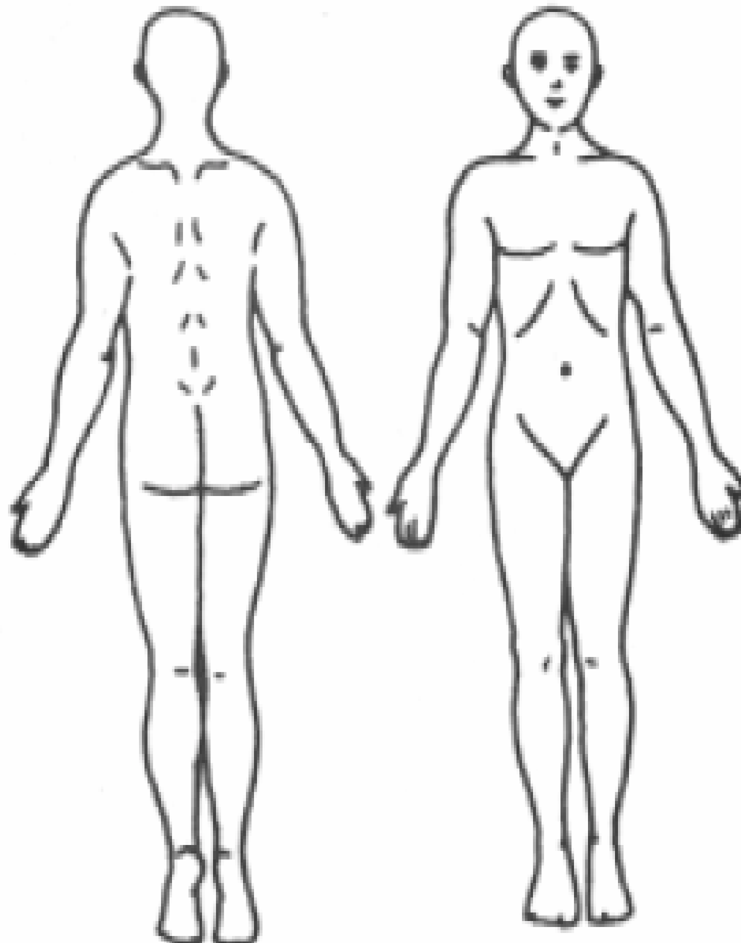
What type of treatment did you receive? ____

What were the results? □ Favorable □ Unfavorable □ If unfavorable please explain:____

List any medications taken to treat this condition: ____

Did they help? □ No □ Yes If you still take them, how often? ____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other, Please list ___________________________

2. PLEASE**, identify** ALL PAST **and or any** unrelated current **conditions you feel may be contributing your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM

PREVIOUS ACCIDENTS ____

____

ADULT DISEASES ____

SURGERIES ____

CHILDHOOD DISEASES ____

Patient or Authorized Person's Signature ______________________ **Date: _____ / _____ / _____**

Provider Initials: ____________

Effects of Current conditions on Performance

Patient Name: ______________________________ Date: ______________

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

MOVEMENT	MEASUREMENT ↓	1 2 3	4 5 6	7 8 9	10
Bending neck forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending neck backward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Turning neck right to left		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Turning neck left to right		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Twisting from the waste		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending side to side		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending backward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing **(how long?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going from standing to sitting		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting **(how long?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going from sitting to standing		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going form sitting to lying down		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lying down **(how long?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going from lying to sitting up		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling over when lying down		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extending arms overhead		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extending arms forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing **(how many lbs?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pulling **(how many lbs?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting more than **(lbs.?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking or running **(miles?)**		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing uphill (stairs, ladders)		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking downhill		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Doctor Signature: ______________________________ Date: ______________________________

Princeton Spine Disc & Chiropractic Care, LLC

Patients Name: ____ DOB: _________________ Date: __________________

Medications List

Medication	Date Prescribe:	Dosage:	Frequency	Purpose:

Non Prescription	Date Prescribe:	Dosage:	Frequency:	Purpose:

Vitamins	Date Prescribe:	Dosage:	Frequency:	Purpose:

Patients Signature: ____

Providers Signature____________________________